The Modern Hospital

MAY 1959

How To Give the Public the Facts About Hospital Costs

Everybody in the hospital who sees patients and visitors should be prepared to give the right answers — but first they must listen to the questions (*page* 91)

Don't Just Sit There — Lead the Meeting!

Success of a conference depends on the leader's ability to keep it on the track; leaders must be carefully selected (*page* 100)

Two Articles on Medical Staff Organization Problems

A former Navy pilot suggests that doctors, like pilots, must be considered as individualists, not team members (*page* 59). *What is the courtesy staff?* (*page* 85)

Front entrance, Jefferson Memorial Hospital, Festus, Mo. (*page* 88)

introducing a new concept in hospital furniture

VENTURA . . . by Royal

metal room furniture with completely replaceable parts

It's here — the first basic improvement in design and construction since the inception of metal furniture! *Ventura* . . . a complete line of chests, dressers, and bedside stands that permits you to choose individual panels for every surface, from a broad range of materials and finishes that blend harmoniously with Royal's many different patient beds, overbed tables, chairs and lounges.

Never Before . . . Such Beauty, Flexibility, Versatility

Ventura . . . by Royal gives patient rooms truly custom-made furniture, at production-line prices, with an almost limitless combination of materials and colors. *Tops* include Plastelle-enameled metal, Royaloid over plywood, and solid Fiberesin. *Fronts* may be Plastelle-enameled metal, or solid Fiberesin. (All Fiberesin panels available in warm natural birch, walnut, cherry or butternut finishes.) *Legs*: square-tube steel Plastelle-enameled or satin finish. *Sides and Backs*: Plastelle-enameled metal.

Never before . . . Such Ease of Maintenance!

Ventura . . . by Royal features quickly replaceable tops, drawer fronts and side panels which attach to sturdy "sky-scraper" inner steel frames . . . repair jobs are made right in the room without inconvenience to patients or disruption of normal routine.

We think you'll agree that there - at last - is the last word in modern hospital furniture. Write for specifications, prices and full information on beautiful, colorful *Ventura* . . . by Royal!

ROYAL METAL MANUFACTURING COMPANY

One Park Avenue, New York 16, N.Y., Dept. 8-E. Distributors in principal cities.

ERGOTRATE® MALEATE contracts the uterus, speeds involution, and prevents hemorrhage

Ergotrate Maleate almost completely eliminates postpartum hemorrhage due to uterine atony. Administered during the puerperium, it increases the rate, extent, and regularity of uterine involution; decreases the amount and sanguineous character of the lochia; and decreases puerperal morbidity due to uterine infection. Ergotrate Maleate is available in 1-cc. ampoules of 0.2 mg. and in tablets of 0.2 mg.

Ergotrate® Maleate (ergonovine maleate, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

959005

The Modern Hospital

MAY 1959 VOLUME 92, NO. 5

Articles in this issue

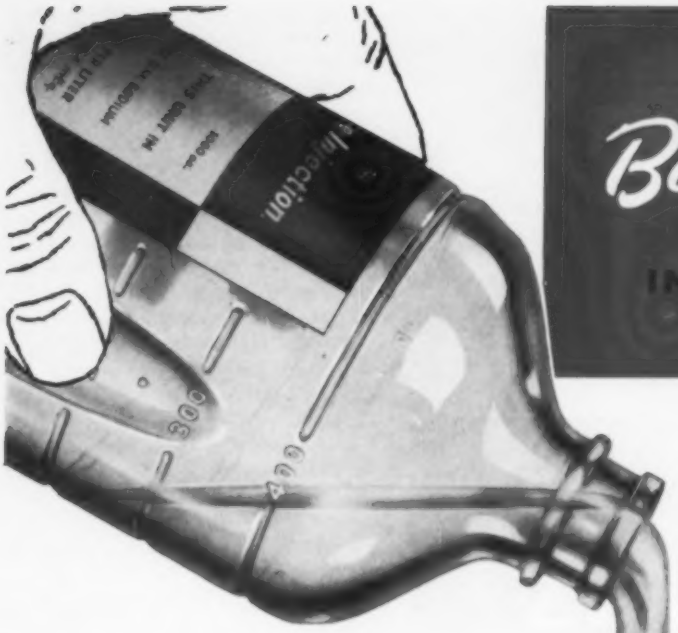
Continued on next page >

Editor, ROBERT M. CUNNINGHAM Jr. *Managing Editor*, AARON COHODES
Associate Editors, MILDRED WHITCOMB, JANE BARTON *Assistant Editor*, LUCIGRACE SWITZER *Art Director*, LOIS K. BAUMAN
Advertising Director, J. W. CANNON Jr. *Chicago Advertising Offices*: 919 N. Michigan Ave., Chicago 11, Ill.
Eastern Office: 119 W. 40th St., New York 18, N.Y. *Cleveland Advertising Office*: 19030 Westlake Road, Cleveland 16, Ohio
Western States Advertising Representative: Bob Wettstein & Associates, Los Angeles, San Francisco

The Modern Hospital

Published monthly by The Modern Hospital Publishing Company, Inc. (subsidiary of F. W. Dodge Corporation), 919 North Michigan Avenue, Chicago 11, Ill., U.S.A. (Cable Address: Modital, Chicago.) Howard Barringer, president; Robert F. Marshall, executive vice president; Robert M. Cunningham Jr., vice president and editorial director; H. Judd Payne, vice president; J. W. Cannon Jr., assistant vice president; Stanley R. Clague, secretary; John P. McDermott, treasurer. Subscription price in U.S., U.S. Possessions and Canada, $5 a year and $8 for two years; elsewhere, $7 a year and $12 for two years. Single copies, $1. Member Audit Bureau of Circulations, Associated Business Publications. Second class postage paid at Chicago, Ill., and at additional mailing offices. Printed in U.S.A. Thirty days in advance of publication date should be allowed for change of address.

Change of address notices, undeliverable copies, and subscription orders should be sent to: THE MODERN HOSPITAL, 919 North Michigan Ave., Chicago 11, Ill.



Busiest Bottle

IN ANY HOSPITAL

From O.R. to Nursery . . . from Pharmacy to Emergency Room . . . wherever sterile, distilled water, normal saline and irrigating solutions are used, this modern pour bottle is on hand. Functional design, convenient screw cap, and sure-grip finger grooves are among the basic reasons for its growing preference.

These liter-size pour bottles conserve hospital time . . . reflect direct savings in fluid preparation, material costs, labor costs, overhead costs. Control and safety factors are constant . . . while present equipment may be freed for other uses.

Pour bottles are finding increasing use for irrigation and other washing and rinsing procedures in the OPERATING ROOM . . . for rinsing and preparation of syringes, needles and other I.V. equipment in CENTRAL SUPPLY . . . in the preparation of small R_x items in the PHARMACY . . . for preparation of specific diets in the INFANT FORMULA ROOM . . . as a source of sterile water and saline for washing and rinsing in the NURSERY . . . at NURSING STATIONS . . . in the OUTPATIENT DEPARTMENT . . . in the DELIVERY ROOM . . . in the EMERGENCY ROOM.

For these uses, and for *re-use* functions of the bottle itself, more and more hospitals are standardizing on this most versatile unit.

NOW AVAILABLE IN MULTI-USE POUR BOTTLE

Cat. No. G94	DISTILLED WATER
Cat. No. G104	NORMAL SALINE
Cat. No. G124	UROLOGIC SOLUTION G Irrigating solution for dissolution of urinary tract calculi
Cat. No. G134	GLYCINE 15% IN WATER Urologic irrigating solution.

BAXTER LABORATORIES, INC. MORTON GROVE, ILLINOIS

DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH

AMERICAN HOSPITAL SUPPLY CORPORATION

SCIENTIFIC PRODUCTS DIVISION GENERAL OFFICES • EVANSTON, ILLINOIS

For additional information, use postcard facing Cover 3.

READER OPINION

Readers Look at "Look"

Sirs:

Reader response to "Report on Hospitals" was immediate and overwhelming. The article pulled more reader mail than any other article in *Look's* 23 years of publication.

Few of the letters were casual; nearly all were long and vehemently for or against the article. Many of the writers (both pro and con) said that this was the first time they had written a "letter to the editor." Obviously, the article aroused strong personal feelings.

The letters split almost evenly for and against. As to be expected, about 90 per cent of the "pros" were from the general public: either former patients or relatives of patients. Similarly, about 90 per cent of the "cons" were from professional personnel: physicians, hospital administrators, nurses and aides. Such a split highlights your thought concerning the different image of hospitals held by the profession and the public. Perhaps it will be more revealing to examine some of the minority responses – a few of the letters from some of the profession who said that the article was justified, and a few from the public who thought it was not.

Twelve administrators not only applauded the article but also requested reprints for distribution to their hospital staffs. Another administrator wrote in to say that he was providing each patient in the hospital with a copy of the *Look* article requesting that it be read and then asking each patient to write down his feelings about the kind of care he was getting in his hospital.

Among the physicians who favored the article several pointed out that a significant number of physicians strongly favor hospital reforms. Several suggested other hospital abuses that should be corrected and were not covered in the article. One medical man said that if he had read the article six months previously he would have condemned the story but since he recently had spent several months in a hospital as a patient himself he thoroughly agreed with the article. Approving letters were also received from a number of psychiatrists who pointed out that their views on the emotional needs of a patient had long been ignored by medical and hospital personnel. One, a director of a well known center for residency training in psychiatry, asked permission to reprint the article for distribution to his residents.

Although the majority of letters from nurses were bitterly opposed to the article, a significant number said that the article was justified. These dissenting "pros" included student nurses as well as graduates with many years of experience. Mainly they blamed the influx of poorly trained aides taking over many of the nursing duties.

Although 90 per cent of the letters from the general public applauded the article there were some who felt that the article was unjustified and unfair to hospitals. These individuals wrote at length about the wonderful care they had received when they were hospitalized. Each recounted his ex-

Styled for lasting beauty...built to last a lifetime

HARD'S DORM-DUET ROOM GROUP

SHOWN ABOVE

6853-A Desk—Top 21" x 44"
1625-FL Bed—36" x 76"
(Also available with NS-4 Spring)

2133 Nite Stand—Top 16" x 16"
5543 Four-Drawer Chest—Top 19" x 32"
7294 Side Chair
7340-P Easy Chair

Available in a variety of color combinations

HARD

Rarely seen together are the graceful design and rugged construction of Hard's new Room Group for Dormitories. Famous Hard Life-Long Metal Construction makes the combination possible — and at prices that make it a reality for your furnishing plans.

See your Hospital Supply Dealer or contact Hard for complete information.

MANUFACTURING COMPANY *BUFFALO 7, NEW YORK*

perience describing in detail the kindness and attention he received. It is significant that in each of these letters extolling hospitals, the writer referred to the kindness of one individual – a physician, nurse or attendant. None referred to the hospital's physical equipment; opinions seemed to be equated to a human factor.

Several items in the article drew the most heated replies. One was the opening statement about hospitals being unfit places in which to be sick. Although three national opinion surveys previously had published a similar conclusion, it received the most critical comments from the professional group who labeled it inflammatory and sensational. The next most frequent criticism from the professional audience was the charge that the *Look* article indicted thousands of hospitals on the basis of an investigation conducted at only eight California institutions. Most of the criticism on this point came from the more sophisticated members of the professional group – hospital administrators – who, perhaps, were unaware that the conclusions of the limited investigation are supported by other surveys and studies in the scientific literature.

The third most frequent cause for criticism was the statement in the article that hospitals are run for the convenience of the staff and not for the benefit of the patient. The physicians who criticized this claimed that hospitals were not run for their convenience because they had to adhere to rigid rules and regulations such as inconvenient operating schedules. They pointed out that hospital activities were organized primarily to meet the convenience of traditional nursing schedules. The nurses who criticized this point agreed that hospitals were run for the convenience of doctors but not nurses. They claimed that the nurses were "low men on the totem pole" in the hospital caste system.

Some of the critical letters from the profession were strongly worded and personal. A number of them hoped that in the near future I would get ill and have to be hospitalized. In that event they hoped I would eat my words page by page. A few warned me not to get ill and seek treatment in a hospital. (I won't if I can help it.)

Although reader response to "Report on Hospitals" was interesting and stimulating, it has no scientific value in judging the worthiness of the article. It does indicate that the public, as well as the profession, has strong emotional feelings about hospitals. Personally, all I learned from the response is that to some of my readers I am a hero – "a courageous reporter who writes the truth"; to others I am a villain – "an irresponsible reporter writing in the tradition of yellow journalism." It is quite confusing and difficult to figure out. All I can do is to continue as I have in the past: report the facts as I find them and let the public write my epitaph as it will.

Roland H. Berg
Medical Editor

Look Magazine
New York

Sirs:

The most amazing part of Dr. Robert Myers' article ("A Surgeon Looks at *Look*") in the March 1959 issue of The MODERN HOSPITAL is his sweeping denial that hospitalization plays a role in the psychological development of a child. It is indeed a sad commentary on the state of medical progress that a man of Doctor Myers' influence in medical and hospital affairs should be so callously unaware of interpersonal relationships and the many studies that have been made in this important field.

Lest Doctor Myers lead others down the narrow path he is treading, let me point out that when I was gathering research material in preparation for writing "Report on Hospitals" in *Look* Magazine, I compiled 56 individual references in the scientific literature on the emotional implications of hospitalization on children. This is by no means the complete bibliography on the subject; it represents only the most recent writings in the professional literature.

Doctor Myers' point of view reminds me of a recent statement by Dr. Milton J. E. Senn, director of the Child Study Center at Yale University, ". . . some psychological damage commonly results from the kind of management provided for the sick child. This is especially true of hospital care. The fault lies not in unscientific or inadequate care, but more in the lack of understanding of the nature of children and their emotional needs, the feelings and concerns of parents, and the influence of attitudes, beliefs and emotions of professional people as they deal with the sick."

Roland H. Berg
Medical Editor

Look Magazine
New York

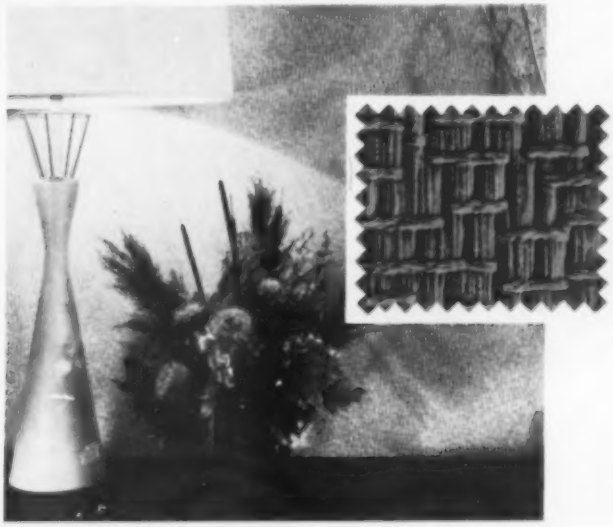
B.F.Goodrich

See how B.F.Goodrich Koroseal helps make an old hospital new again

Colorful playroom brightens the hours for junior-sized patients. Koroseal Rope Square pattern—in golden-yellow, pale blue and lovely lavender—covers giant hassocks.

After 108 years, St. Joseph's Hospital in Philadelphia got a wonderful new look—thanks to a brilliant redecorating job by interior designer Ken White, who made abundant use of B.F.Goodrich Koroseal fabric-backed vinyl materials. Durable Koroseal keeps its original beauty for years, cleans easily with soap and water, cuts maintenance costs by eliminating the need for periodic painting. To give fresh charm to both walls and furniture, specify Koroseal.

For free swatches, write Dept. MH-5. *B.F.Goodrich Industrial Products Company, Marietta, Ohio.*



Rich-textured Koroseal Bali wall covering brings a subtle tropical touch to the conference room (see swatch).

Koroseal wall covering, white Koroseal bench and tangerine Koroseal chair accent the cypress paneling in the administrator's office.

Koroseal®

wall covering and upholstery

B.F.Goodrich ***Koroseal supported vinyl fabrics***

ROVING REPORTER

"Little Things" Mean Much

It's the little things, plus a big-hearted administrator, that make Sunhaven Sanitarium, Jacksonville, Fla., a pleasant place for convalescing patients.

Among the special touches are window flower boxes in every sickroom, daily periods outdoors for all patients, and occasional "pajama parties" that have proved popular with both young and old.

Attractive main lounge with display of The Modern Hospital in wall rack.

Behind it all is Mary Head, administrator, who never seems to be too busy to fluff a patient's pillow, adjust a TV set, or find a special magazine for a bedfast patient to read, according to a feature article in a local newspaper.

On duty officially from 7 a.m. to 7 p.m., Mrs. Head is also unofficially listening 24 hours a day. An intercommunications system set up at the hospital sends messages from patients' beds to her all during the night.

In the main lounge one whole wall is covered with a display of The Modern Hospital — each issue for the last four years, according to Marion Pippin, nurse supervisor at the sanitarium.

Rosie Marks the Spots

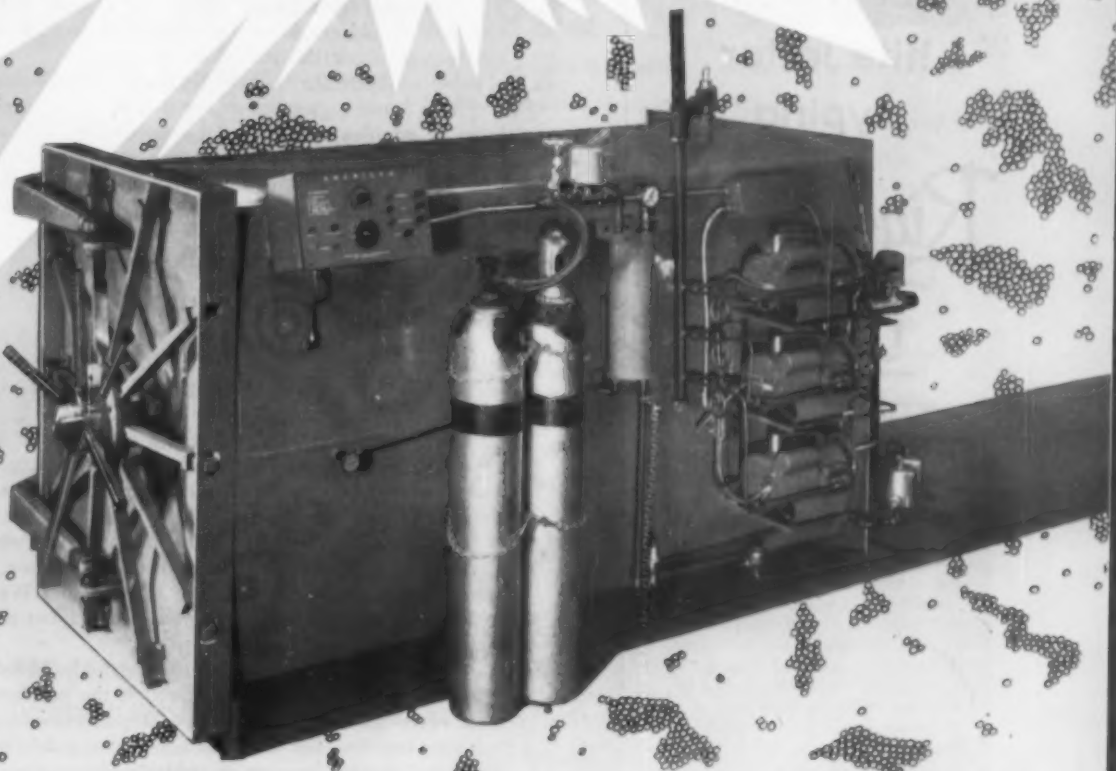
Whenever an employe at Aultman Hospital, Canton, Ohio, suffers an on-the-job injury, Rosie gets another bandage or splint. Rosie, explains George R. Wren, director of the hospital, is a safety mannequin to help remind employes of the importance of safety practices.

Employes can count injuries by what happens to Rosie, safety mannequin.

Rosie appears in the employe cafeteria for about a week each month with bandages, splints and dressings to mark the sites and types of employe injuries on the job during the preceding month.

The idea was developed by the hospital safety committee, composed of 18 employes from all levels of hospital personnel, according to Mr. Wren. The mannequin was donated by a local department store.

A *NEW* WEAPON IN THE WAR AGAINST STAPH!



AMERICAN

MATTRESS *and* BEDDING DISINFECTOR *with special* LOADING CAR

A special-purpose Ethylene Oxide unit combining minimum investment and low processing cost with simple, effective operation

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

Write today for bulletin SC-306

How Is It Possible To Justify Public Relations Expenditures?

By Gordon Davis

Gordon Davis

ALL this talk of public relations is fine and I agree we ought to do something about it," said the administrator. "But our hospital just can't afford it."

Nonsense! The statement is self-contradictory.

What the administrator really was saying was that he did not have the slightest understanding of either the nature or the purposes of public relations. He was listening, but he wasn't hearing.

This is not a grievous sin, or if it is, we're all sinners. We can listen to an idea and nod affable agreement, but we don't really commit ourselves until we support acquiescence with action.

When the need for action becomes inescapable, somehow—magically—there develops the money, the manpower, the energy, and the machinery to support it—provided there is still enough time.

Still, it is hard not to go on the defensive about public relations expenditures. Suppose someone criticizes? How are we going to prove that we are spending this money wisely?

We might argue that soundly conceived and executed public relations activity more than pays its own way. If it's good, it should accomplish this purpose. Indeed, it's possible to demonstrate dollars and cents savings in specific applications.

But that's begging the basic question. No one asks that we apply financial yardsticks to the end products of our churches, schools and libraries, to our spiritual and cultural activities, to friendship, to the worth of common understanding between men.

We spend freely on the intangibles in which we believe. If we have difficulty in justifying public relations expense, it follows that we do not believe public relations effort is needed. We may be willing to accept it if it comes easily and at no cost, but not if it involves commitments.

There are various reasons for this attitude. Sheer administrative pressure—lack of time to think through the problem—may be one. Fear of criticism may be another. Misunderstanding of the public relations function—the persistent notion that public relations consists largely of getting newspaper publicity—unquestionably is another.

Perhaps the foremost is our innate inability to believe that very many people can possibly misunderstand or dislike us. Most hospital administrators are devoted to human service. They are trying hard to serve well, and they know it. Somehow they feel that this good service should speak for itself, that interpretation is a luxury in the diamond and mink coat class.

It is even possible that some administrators think that the problem belongs to the other fellow, that others are responsible for today's free-swinging criticism in editorial columns, in public opinion analyses, at Blue Cross rate hearings, and during cocktail hour gossip fests.

So be it. These are reasons for public relations inaction. Their validity is another question.

But let's not pretend that lack of money is the paralyzing ingredient when the real impediment is lack of conviction. ■

ARE YOUR UNLINED WASTE CANS CAUSING CROSS INFECTION?

Unlined Waste Cans and Exposed Refuse Invite Cross Infection

PRO-TEX-MOR™ DISPOSABLES

STOP THIS DANGER BY...

1. Isolating waste to prevent contamination of metal containers
2. Making removal of waste quick, simple, safe

PRO-TEX-MOR WASTE CAN LINER

Extra heavy wax coated bags prevent leakage, protect metal from stain, rust, contamination. Four sizes to fit all types of waste cans and containers. Fifty bags are packaged in a sturdy, reusable plastic bag for convenience and ease in handling.

PRO-TEX-MOR "JUMBO" WASTE CAN LINER

Collection of refuse is more efficient, economical and sanitary with these giant liners. Specially treated paper with tops long enough to tie securely for removal. Cuts down on air-borne bacteria. Eliminates noise, odors, littering floors. Cans stay cleaner, last longer.

OTHER PRO-TEX-MOR DISPOSABLES

Puro-Cap Nipple Covers • Syringe, Catheter, Glove and Needle Sterilizer Bags • Bedpan Covers • Urinal Covers Examination Sheeting • Examination Gowns • X-Ray Film Envelopes • Pillow and Mattress Covers

PRO-TEX-MOR MEDICAL DIVISION
CENTRAL STATES PAPER & BAG CO.
5221 Natural Bridge • St. Louis 15, Mo.

SOLD EXCLUSIVELY THROUGH HOSPITAL AND SURGICAL SUPPLY DEALERS

KEEP FLOORS CLEANER, SILENTLY...

THE BRIGHT WHITE WAY!

Illustrated in photo: **WARDMASTER SENIOR**
Rugged, heavy steel; with "Can't Splash" wringer

Modern hospitals find White *Silent Cleaning Equipment* superior to anything else on the market for keeping floors aseptically clean . . . *quietly*. White *Silent* tools are rubber-buffered against sound at every point of contact. There are no metal-to-metal moving parts. Whispering through their work, they roll silently from room to room, leaving fresher, cleaner floors behind them. Even inexperienced labor does a much better cleaning job — quietly!

That's why you'll find more White tools in use in America's hospitals than all other brands put together.

FREE CATALOG Ask your dealer for the White catalog, showing the world's ONLY complete line of floor cleaning tools and accessories — or write us for name of nearest White dealer.

follow the WHITE LINE to quicker, better, quieter cleaning!

WHITE MOP WRINGER CO., Fultonville 6, New York

ILLNESS HAS NO TIMETABLE. It may strike without warning, day or night. To meet all emergencies, community hospitals stand ever ready with the finest care medical science and modern facilities can provide.

Moreover, to accommodate the steady rise in the number of patients each year, hospitals are constantly adding to their staffs and expanding and strengthening "around-the-clock" services.

The quality of hospital care is higher today than ever before. More rapid recovery and shorter hospital stays for patients have been achieved by new advances in diagnosis and treatment . . . with long strides taken in research, training, surgery, and methods of rehabilitation.

On the occasion of National Hospital Week, May 10-16, 1959, we congratulate the nation's community hospitals for their untiring and skilled service to the public.

HEALTH · INSURANCE · COUNCIL

HEALTH INSURANCE COUNCIL

Representing the nation's insurance companies

NEW

ETHI-ROLL™ SURGICAL SILK AND COTTON

Tru-Permanized Surgical Silk and ETHICON Surgical Cotton are now provided in the ETHI-ROLL Package with new "cut-your-own" convenience. Just pull out, measure the desired length on the box and then cut. Twenty 30 yard strands in each ETHI-ROLL box.

ETHICON®

NEW

ETHI-PACK® SURGICAL SILK

PRE-THREADED TO EYED NEEDLES

Tru-Permanized Surgical Silk Pre-Threaded to straight taper point eyed needles, ready to autoclave. No kinked or tangled strands. Just sterilize sections of six individually sealed sutures, and they're ready to use. 24 sections of six sutures per box.

ETHICON®

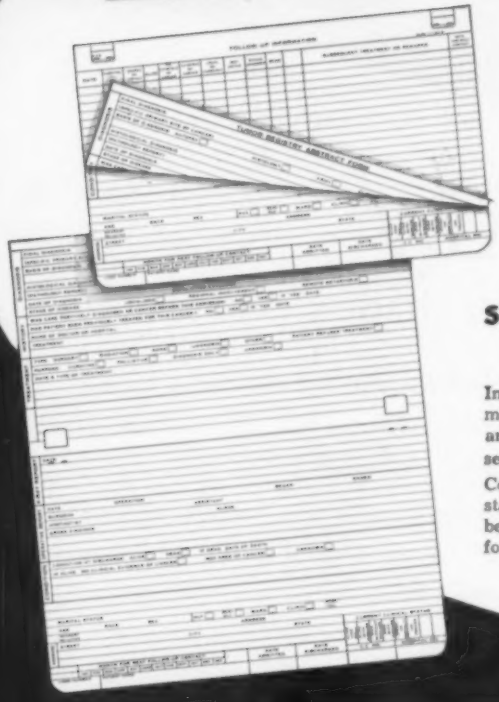
ACME VISIBLE

Simplified

Tumor Clinic Register

provides

- **Case History Abstract**
- **Record of Follow-up Findings**
- **Supplemental Remarks**
- **Visualization of Facts**



The 8" x 5" folded, four-page ACME VISIBLE card duplicates the CANCER REGISTRY ABSTRACT FORM illustrated in the "Manual for Registries and Cancer Clinical Activities" issued by the American College of Surgeons in October 1955 . . . with time-saving visualized control features. With the ACME VISIBLE forms and equipment . . . any Hospital or Cancer Clinic can set up a Tumor Case Registry that meets the requirements . . . with a minimum investment of time and money.

SAVE TIME..in posting..reference . . compiling statistical reports

Instant reference and convenient posting without removing record cards . . . refiling and possible misfiling are entirely eliminated. A new record can easily be inserted at any point, maintaining proper sequence.

Color and position of signals indicate current clinical status of the patient. The Annual Statistical Report may be easily and quickly prepared by photostating the information and signals on the exposed edge of the cards.

Services of experienced field representatives and our Hospital Systems Department are available to analyze your requirements and to recommend the most practical system, method or procedure.

MAIL COUPON TODAY

ACME VISIBLE RECORDS, INC. CROZET, VIRGINIA

Please send us booklet H-559

☐ Bulletin #SB46. "Tumor Clinic Register" ☐ #997 "Hospital Record Efficiency"

☐ #971 Acme Tray Cabinets & Card Books ☐ #975 Acme Flexoline Catalog

☐ Have representative call. Date_____ Time_____

☐ We are interested in Acme Visible Equipment for _____ records.
KIND OF RECORD

Hospital_____ Attention_____

City_____ Zone____ State_____

the Key

to reduced radiation exposure

Constant research, development and perfection in Gevaert laboratories today bring you as fine and fast a film as dedicated technicians can produce. Even with a sharp reduction in exposure, your Gevaert film will enlighten your view box with a radiograph of gratifying brilliance and clarity. Seeing is believing.

"NE PLUS ULTRA"

GEVAERT
X-RAY FILM

Exclusive Distributors: Low X-Ray Film Corporation, 161 Sixth Avenue, New York 13, N. Y. ● Other Offices: 9109 Sovereign Row, Dallas 35, Texas ● 725 No. Highland Ave., Los Angeles 38, Calif. ● 6611 No. Lincoln Ave., Chicago 45, Ill. ● Nationwide Warehousing

now...for edema and hypertension

Esidrix™

(hydrochlorothiazide CIBA)

milligram-for-milligram the most effective oral diuretic-antihypertensive

Greater activity: Milligram-for-milligram, Esidrix is the most effective oral diuretic known. With a therapeutic efficacy comparable to parenterally administered mercurials, Esidrix is from 10 to 15 times more potent than chlorothiazide and therefore provides the same therapeutic benefits with but 1/10 to 1/15 the dosage. Animal studies indicate that Esidrix is longer acting than chlorothiazide, providing a smoother response.

Low toxicity: According to animal studies, Esidrix is markedly less toxic than chlorothiazide and is therefore an exceptionally safe diuretic-antihypertensive.

Patients unresponsive to chlorothiazide and mercurials in many cases respond readily to Esidrix.

Use in hypertension: Esidrix may be used alone or in combination with other antihypertensive drugs to bring about effective lowering of blood pressure. The drug potentiates the action of all other antihypertensive agents, including SINGOSERP, SERPASIL and APRESOLINE. Dosage (and side effects) of other agents often can be reduced when they are given with Esidrix.

Less dietary salt restriction: In many cases, Esidrix permits some moderation in severe sodium restriction and therefore makes meals more palatable. Side effects are usually not severe and most of them can be overcome by adjusting the electrolyte balance (through dietary supplements), lowering the dose or administering the drug after meals.

Dosage: Esidrix is administered orally in an average dose of 75 to 100 mg. daily, with a range of 25 to 200 mg. A single dose may be given in the morning or tablets may be administered 2 or 3 times a day.

Supplied: TABLETS, 25 mg. (pink, scored); bottles of 100.
TABLETS, 50 mg. (yellow, scored); bottles of 100.

SINGOSERP® (syrosingopine CIBA)
SERPASIL® (reserpine CIBA)
APRESOLINE® hydrochloride (hydralazine hydrochloride CIBA)

CIBA
SUMMIT, N.J.

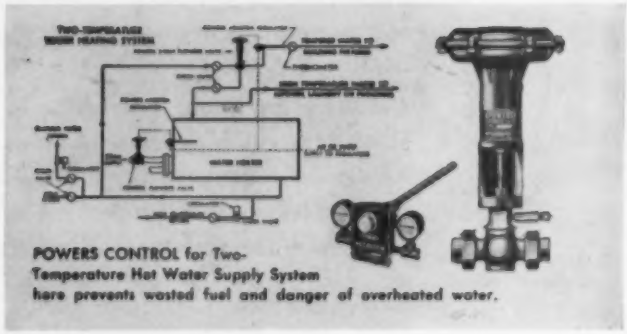
ESIDRIX · relieves edema in many patients refractory to other diuretics; produces greater weight loss, greater average reduction in blood pressure; with less likelihood of electrolyte imbalance

In Colorado's largest private general hospital

ST. MARY-CORWIN HOSPITAL
PUEBLO, COLORADO
Architects: MONROE, IRWIN & DUNHAM, Denver, Colo.
Mechanical Engineers: MARSHALL & JOHNSON
Mechanical Contractor: NATKIN & COMPANY
General Contractor: ROBERT E. McKEE

For more than 75 years the Sisters of Charity have been caring for the sick in Pueblo's St. Mary Hospital. Now its new imposing structure the St. Mary-Corwin Hospital contains modern facilities unsurpassed for diagnosis and treatment of disease, patient care and comfort. Powers Temperature Control here helps increase hospital efficiency.

Above: Recovery room for efficient post operative care



POWERS CONTROL for Two-Temperature Hot Water Supply System here prevents wasted fuel and danger of overheated water.

(D8)

THERMAL COMFORT throughout is provided by POWERS Temperature Control for each individual room and various types of baths

Proper Thermal Environment is important in this 450 bed hospital. Patients, nurses, doctors and staff benefit from Powers air conditioning control in the surgical suite consisting of 8 major and 3 minor operating rooms, recovery and delivery rooms, X-Ray department, laboratory, maternity department and pediatric unit. Temperature in other spaces is also regulated by Powers individual room control system.

Greater Simplicity and year after year dependability of a Powers Pneumatic Control-System provides these money saving benefits —

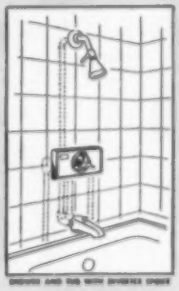
Lower Heating Costs — Powers accurate control prevents discomfort of over-heating and reduces fuel losses.

Lower Maintenance Cost — 25 to 40 years of dependable control with a minimum of repairs is often reported by users of pneumatic control systems. Some are still in operation after 50 years of service.

Powers Complete Responsibility — for a correctly engineered control system, proper installation, continuous successful operation and prompt SERVICE, when required, from offices in 85 cities.

For Sitz Baths, Shampoo Tables, Arm and Leg Baths, etc.

PATIENT'S SAFETY and COMFORT in Hydrotherapy, showers, and infant baths are assured by Powers HYDROGUARD thermostatic water mixers. They are also used for X-Ray film developing, surgeon's wash-up sinks, artificial kidneys, blood coolers in heart surgery and many other applications.



Powers makes the most complete line of water temperature control

732 Powers Pneumatic Thermostats maintain set temperatures constantly. They need no daily checking or readjusting. Patients, nurses, doctors, staff and visitors all benefit from the THERMAL COMFORT they provide throughout the hospital.

NO MORE Valve Packing Maintenance or Water Leakage with Powers PACKLESS Valves.

864 Powers PACKLESS Control Valves are used here on convectors, and unit ventilators. They're labor savers, and cut the cost of maintenance.

Are You Planning a New Hospital? No other single firm makes so many of the essential thermal comfort controls for modern hospitals as POWERS. Only a few are shown above. Ask your architect or engineer to include a Powers Quality System of Thermal Comfort Control—throughout the building for heating, air conditioning, various baths and hot water heaters.

THE POWERS REGULATOR COMPANY

SKOKIE, ILL. | *Offices in 85 Cities in U.S.A. and Canada*

65 YEARS OF AUTOMATIC TEMPERATURE AND HUMIDITY CONTROL

3 Colgate Hospital Products for Outstanding Performance and Welcome Economy

COLGATE COLEO

Laboratory Glassware and Surgical Instrument Cleaner

For laboratory and surgical equipment . . . cleanliness begins with COLEO! COLEO *dissolves* quickly, *cleans* thoroughly, *rinses* freely. Its efficient blood-removal action makes it especially desirable for cleaning surgical instruments and other O. R. and laboratory equipment.

Packed in 50 and 100-lb. Fibre Drums and 5-lb. Cans (6 per case). Write for prices.

COLGATE ARCTIC

Hexachlorophene Surgical Liquid Soap U.S.P.

Highest quality. Conforms to U. S. Pharmacopeia requirements when diluted as directed. Contains special ingredient to prevent clouding and formation of precipitates when diluted with 2 parts hard water (up to 300 PPM). Excellent lathering qualities.

Rinses quickly. So *mild* and *gentle* you can use it on your face!

Available in 30 and 55-gal. Drums and in 5-gal. Pails. Write for prices.

COLGATE BEAUTY WHITE

Made To Order For Hospital Use

Colgate Beauty White meets rigid hospital requirements because it is *made especially* for hospital use. Hard milled for utmost economy, this mildly fragrant bath soap gives *abundant lather* in all types of water. Next time, specify Beauty White. Your patients will appreciate it—and you'll *save money!*

Two sizes packed unwrapped. Also one size available wrapped. Write for prices.

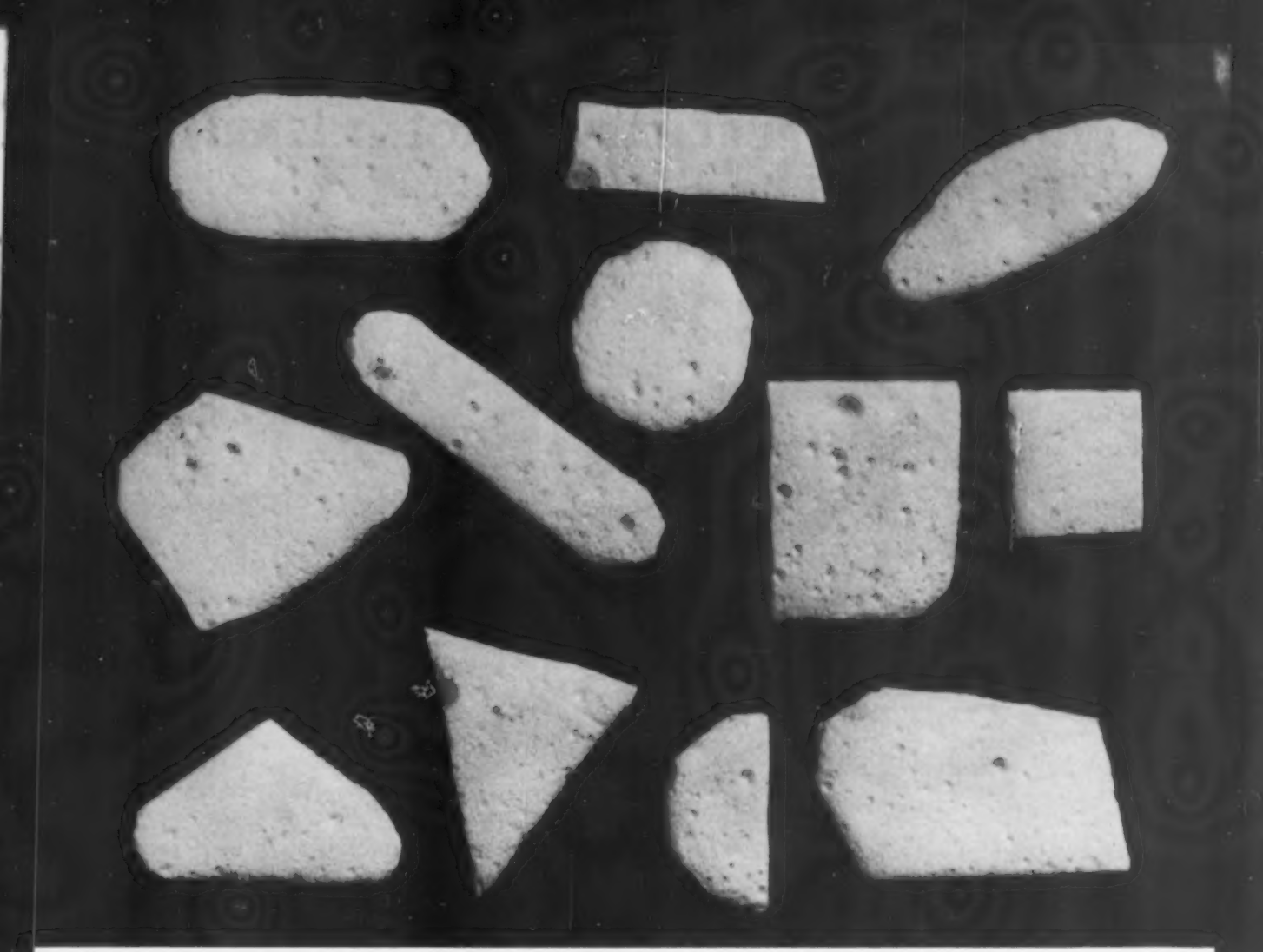
FREE! Latest Edition Handy Soap and Synthetic Detergent Buying Guide. Tells you the right product for every purpose. Ask your C.P. representative for a copy, or write to our Associated Products Dept.

COLGATE PALMOLIVE CO. CP QUALITY PRODUCTS SINCE 1806 A SYMBOL OF QUALITY FOR OVER 100 YEARS

COLGATE-PALMOLIVE COMPANY

300 Park Avenue, New York 22, N. Y.

Atlanta 5, Ga. • Chicago 11, Ill. • Kansas City 11, Mo. • Oakland 12, Calif.



Are you getting the most out of your Gelfoam*?

Blood readily enters the Gelfoam sponge . . . and there it stops—and clots. Left *in situ*, Gelfoam is then absorbed with virtually no cellular reaction.

That's why your hospital undoubtedly stocks Gelfoam. But Gelfoam has so many uses, some of them are sometimes overlooked. Are you taking advantage of all of them?

- to control bleeding from small arteries
- to control capillary ooze
- to repair veins
- to seal cerebrospinal fluid leaks
- to obliterate dead space
- to secure a dry operative field
- to protect surfaces against retraction
- to carry medication
- to stop epistaxis
- to support tissue flaps
- to patch small air leaks in reinflated lungs
- to reinforce suture lines
- to treat gastroduodenal hemorrhage
- to facilitate closure and healing of large kidney wounds
- to stop massive hemorrhage following proctologic surgery
- to aid in the correction of skeletal defects
- to promote granulation tissue growth in skin ulcers
- to perform sponge biopsy

Gelfoam is supplied as sterile surgical sponge, dental pack, prostatectomy cone, biopsy sponge, sterile powder, and Gelfilm* for neurosurgery and ophthalmologic procedures. Make sure you have the right Gelfoam on hand for every use.

*TRADEMARK, REG. U. S. PAT. OFF.

The Upjohn Company, Kalamazoo, Michigan **Upjohn**

WHAT CAN A PURCHASING AGENT LEARN FROM A DIAMOND EXPERT?

One slightest flaw in a gem may cause it to split or shatter when it is cut. And so the gemologist looks for consistency of quality in every stone.

Consistency is important in buying uniforms, too. That's why so many Purchasing Agents, rather than dealing with many suppliers, one for patient gowns, another for operating room apparel, still another for kitchen, nursing, and other departments, have learned that Angelica's complete line of uniforms gives them, *consistently,* all the advantages they had hoped to get:

√ **CONSISTENT HIGH QUALITY**... High standards in choosing materials for durability, colorfastness, and shrinkage-control.

√ **CONSISTENT ECONOMY**...longer wear--savings in repairs--fewer replacements--add up to "more for your money."

√ **CONSISTENT COMFORT**... you can always be sure that all Angelica garments are full cut and always true sizes--no skimping on materials.

√ **CONSISTENT SERVICE**... Fifty trained salesmen, strategically located warehouses and largest stocks of any hospital apparel manufacturer assure you of fast delivery.

√ **CONSISTENCY**...Yes, that's the answer in diamonds or uniforms; the reason so many Purchasing Agents now look to Angelica to supply uniforms for *all* personnel in *all* departments.

HIA HOSPITAL INDUSTRIES ASSOCIATION

Send Today
For Your Copy
Of The New
Angelica Catalog
Of Hospital Apparel

Angelica® UNIFORMS

1427 Olive St., St. Louis 3, Mo. • 107 W. 48th St., New York 36, N. Y. • 177 N. Michigan Ave., Chicago 1, Ill. • 1900 W. Pico Blvd., Los Angeles 6, Calif.

It's about time

someone found a better way and here it is...

An economical, easy-to-use unit for drainage collection that affords patient and nurse added convenience; saves time and money for your hospital.

BARDIC STERILE
BEDSIDE DRAINAGE BAG

Unbreakable plastic, sterile; 2000 cc. capacity. Transparent and calibrated for easy measurement of patient's output.

BARDIC DUAL HANGER

Easily slipped over bed rail or side of wheel stretcher. For ambulatory patients, hanger serves as a handle. Durable plastic coating.

Aids nursing care—provides a simple yet effective "closed system" without special connectors, stoppers or caps. Reduces offensive odors and prevents entrance of air-borne contamination. Sterile bag reduces danger of ascending infection. Unit is easily emptied without fuss or bother.

Solves storage problem—500 bags occupy less shelf area than 2 glass jugs or 4 used i.v. bottles.

Simplifies housekeeping—the Bardic unit, suspended above the floor, helps maintain the neatness and clinical appearance of the modern hospital . . . keeps floor cleared for cleaning, does away with unsightly bottles; eliminates breakage and spilled urine.

The Cost? . . . as little as 5½¢ per day; less than the expense of collecting, washing, sterilizing and storing jugs or bottles.

C. R. BARD, INC. SUMMIT, N. J.

ORDER FROM YOUR HOSPITAL SUPPLY DEALER

593

First from American

New ideas, new products for the operating room...

through one service expert!

American representatives understand operating room needs. They offer valuable experience and expert counsel in every hospital area... and the widest, most complete selection of products and services in the field. You can rely on American's reputation for quality and for prompt, dependable delivery. Your man from American is dedicated to your hospital's best interests... call him with confidence.

Charles A. Barry
of Denver, Colorado.
American Representative
in our Kansas City Region.

The First Name in Hospital Supplies

AMERICAN

2020 RIDGE AVE., EVANSTON, ILLINOIS

Regional Offices: Atlanta • Chicago • Columbus

Hospital Supply Corporation

Dallas • Kansas City • Los Angeles • Minneapolis • New York • San Francisco • Washington

Tomac

You know they'll

Puritan pioneered quick-connect station outlets for hospitals...and more than ten years of continuous, rugged service have proved their ability to provide dependable service under the most exacting conditions and requirements.

When a customer buys from Puritan, he not only receives the item itself... he also receives close to half a century of Puritan skill, know-how, and experience.

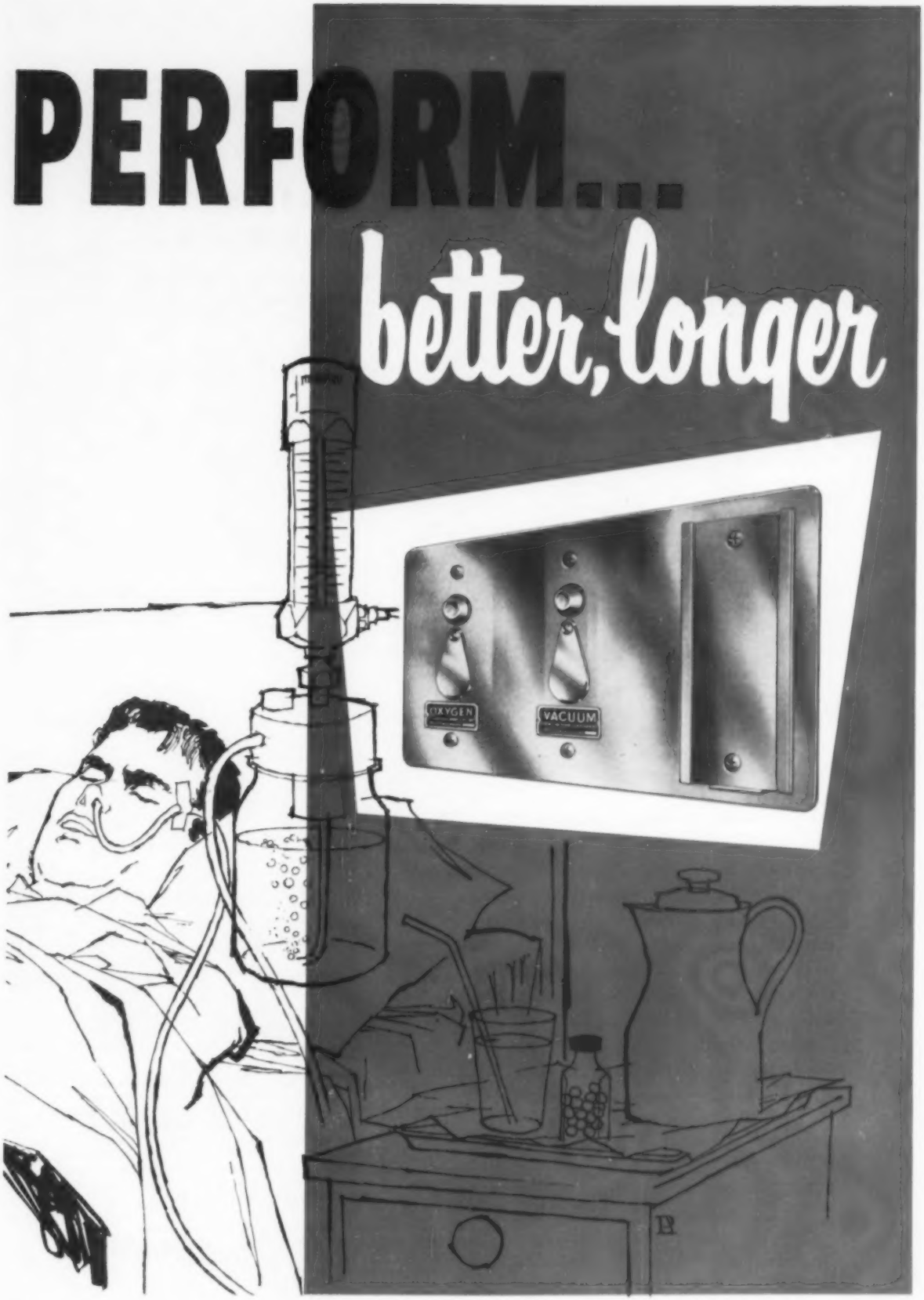
Puritan*

PURITAN MAID

COMPRESSED GAS CORPORATION
SINCE 1913
KANSAS CITY 8, MO.

PRODUCERS OF MEDICAL GASES AND GAS THERAPY EQUIPMENT

Represented in the Far West by
BENNETT RESPIRATION PRODUCTS, INC.
2230 S. Barrington Los Angeles 64, Calif.
A Subsidiary of Puritan Compressed Gas Corp.



For additional information, use postcard facing Cover 3.

American
SQUARE DRESSING STERILIZERS

Maintain the most advanced sterilizing techniques . . . within minimum operator time

The new Square Dressing Sterilizers are research-designed to meet the most exacting of hospital needs . . . with minimum demands upon the time and attention of operating personnel.

The roomy square chamber readily accepts three large trays . . . for maximum production and dependable sterilization of dressings, tray sets, syringes and needles, rubber gloves, flasks, fluids and related surgical supplies.

Made in the Amsco tradition for long, dependable service, the Square Dressing Sterilizer reflects the skills of more than sixty years of thoughtful and continuing research.

Write for Bulletin C-162

Unitized Control Panel

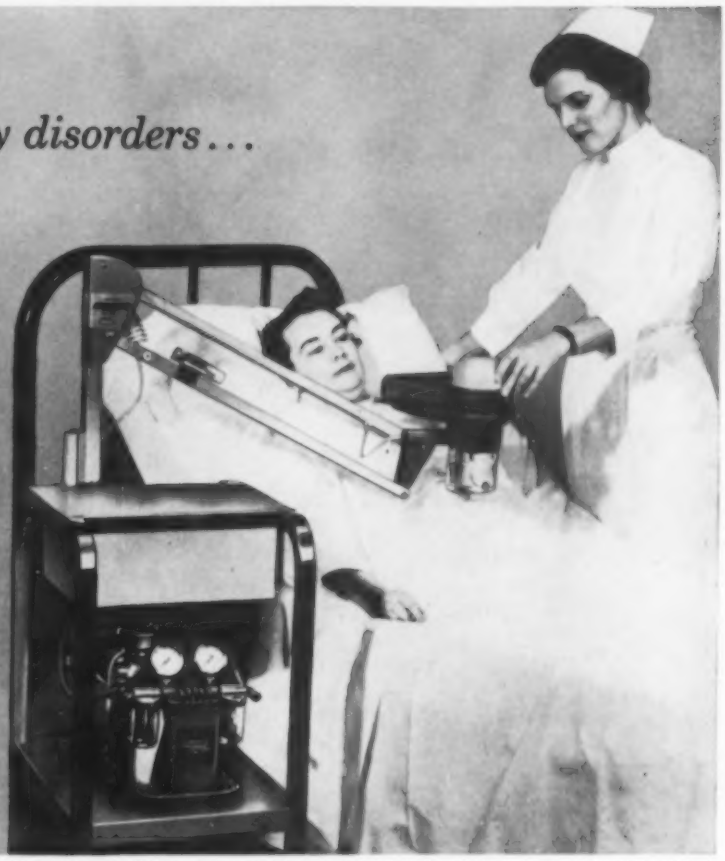
Eye level Control Panel includes Indicating — Recording — Controlling Thermometer and Cyclomatic Control. Simple, direct and positive, Cyclomatic Control begins timing when the selected temperature is reached, sterilizes, exhausts, and dries the load . . . AUTOMATICALLY. Saves steps and time for the operator, materials and steam for the hospital, and worry and uncertainty for the staff.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

WORLD'S LARGEST DESIGNER and MANUFACTURER of SURGICAL STERILIZERS, TABLES, LIGHTS and RELATED PRODUCTS.

in upper respiratory disorders...

cool-vapor therapy without tent...



HYDROJETTE provides cool vapor in therapeutic particle sizes to hydrate upper respiratory tract.

...anywhere in the hospital...quickly, easily, and quietly with the new **Model C Hydrojette®**

The HYDROJETTE also provides bedside suction. Unique MICRO-FILTER removes bacteria from the air before it leaves the DIA-PUMP, reducing hazard of cross-infections.[1]

NEW MODEL C HYDROJETTE® humidifier is unexcelled for convenient, simple, direct administration of cool-vapor therapy in croup, asthma, bronchitis and other respiratory disorders. Cool, moisture-laden fog also relieves intubation irritation and post-operative dehydration of the respiratory tract.

Each Model C Hydrojette consists of—

- **Adjustable, counterpoised Hydrojette Arm** and vapor delivery head to provide cool mist *at the airway* without mask or tent. The delivery head may be adjusted to any position by the patient, thus saving valuable nursing time. This movable arm fits a special bracket on the . . .
- **New Hydrojette utility table.** Rolls quietly and easily on large rubber casters to any room or ward in the hospital. The sturdy lightweight table provides stainless steel work surface, handy storage drawer and a "floating" vibration-free platform on hollow rubber suspension mounts for the . . .
- **Trouble-free Dia-Pump®** compressor-aspirator, with new MICRO-FILTER which removes microscopic air contaminants down to 0.5 micron in size, to provide a *safe* source of compressed air to operate the HYDROJETTE.

1. Ranger, I. and O'Grady, F.: Lancet 2:299, 1958.

For complete HYDROJETTE literature fill in and mail this coupon to ▶

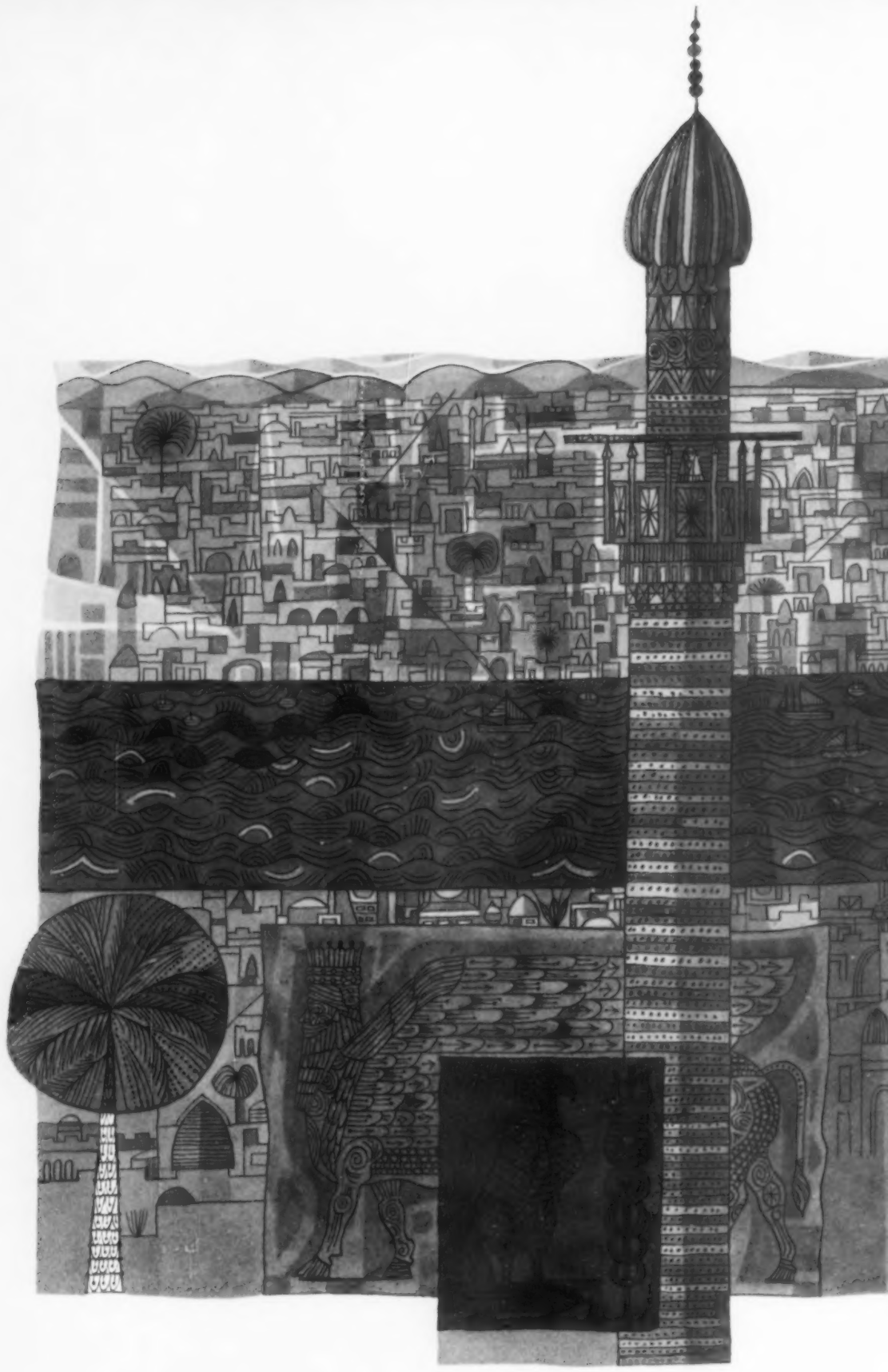
The new Model C **Hydrojette®**

mobile humidifier-aspirator by **AIR-SHIELDS, INC.**

Hatboro, Pa. OSborne 5-5200

Air-Shields, Inc. MH
Hatboro, Pa.
Gentlemen:
Please send literature on New **Model C Hydrojette.**
Name_____
Hospital_____
Street_____
City_____ Zone_____ State_____

For additional information, use postcard facing Cover 3.



thomas thomas

RELIABILITY IN ACTION

How much does your parenteral solutions dollar buy? There is more to consider than you see on the invoice.

For example, does your solutions manufacturer maintain his own distribution branches, so that fresh stocks are always nearby? Is his selection complete? Can you count on receiving whatever you want, whenever you want it? Does he offer you an experienced staff of field specialists devoted full time to hospital service? Does

he provide y
as well, to he
size?

If your sup
they are wo

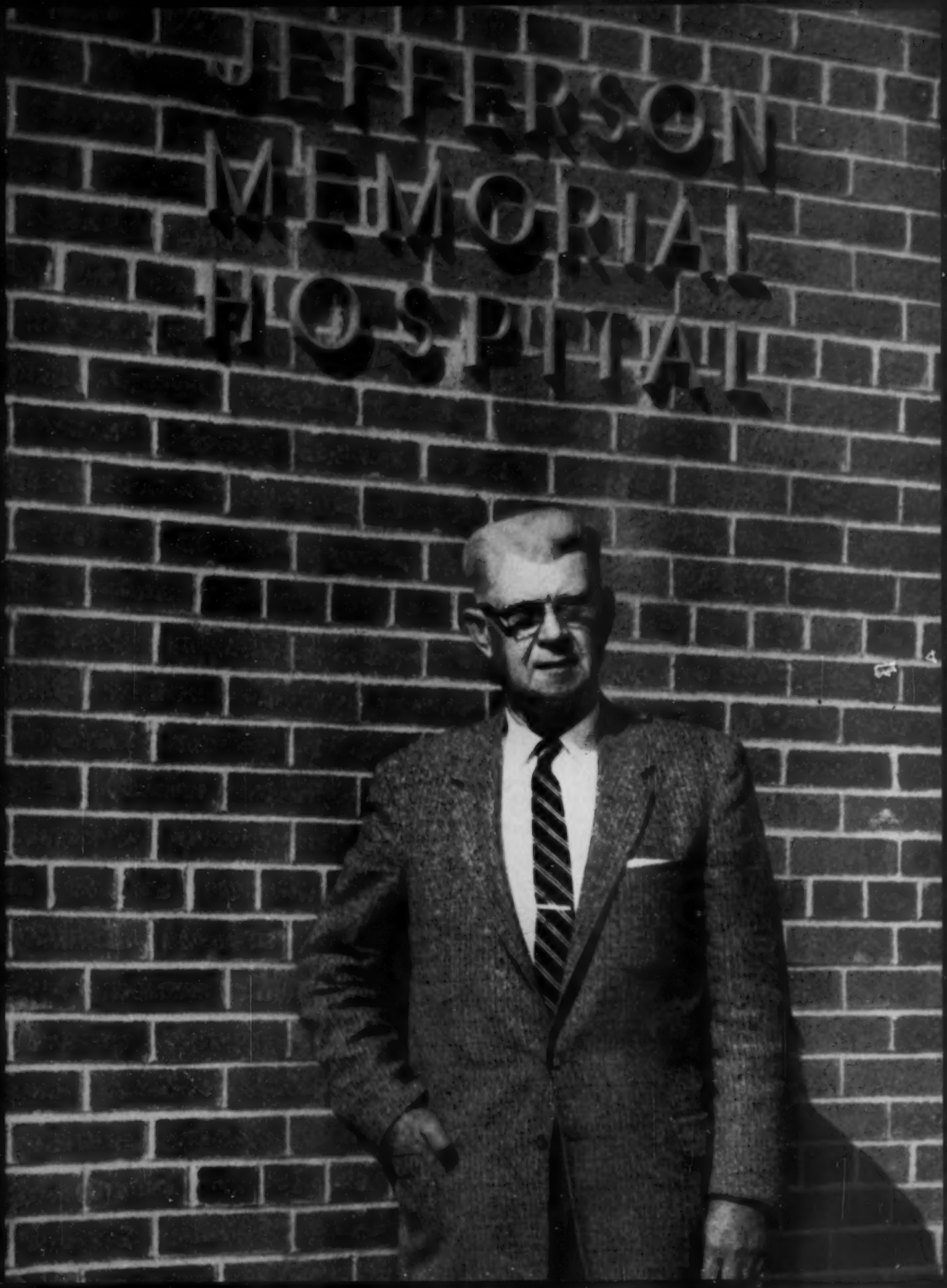
ABBO
SOLUT

BABE RUTH—
reliability in action
as painted by
Tom Allen.
For a handsome
wide-margin print,
write Professional
Services, Abbott
Laboratories,
North Chicago,
Illinois.

de you a broad line of general pharmaceuticals
to help build your orders to more advantageous

r supplier is Abbott, the answers are *yes*. If not,
worth discussing with an Abbott man. Soon.

BOTT PARENTERALS
UTIONS AND EQUIPMENT


JEFFERSON
MEMORIAL
HOSPITAL

HOSPITAL ADMINISTRATOR

TRUE TAYLOR ASKS:

"WHY DON'T YOU TALK TO THE MEN AT CUMERFORD ABOUT RAISING THE MONEY?"

by True Taylor, administrator,
Jefferson Memorial Hospital, Crystal City, Missouri

"Our campaign was a tough one for any fund-raiser. You see, the Crystal City-Festus community is only a few miles outside of St. Louis, a city filled with excellent hospital facilities.

"Many of the men here in our town said, 'It couldn't be done!' Even though we were sure we needed a hospital very much.

"Still, the men from Cumerford came in and raised $469,435.00 (on a goal of $350,000.00) from a community of only 3,000 families.

"We had Cumerford men here on two occasions. First, when the major capital funds drive went on. Then later, we found we wanted more facilities in our hospital. We decided to add more beds and rooms. So they returned for a six-week campaign to provide the additional money.

"Something else about Cumerford: these men *know* how to work with people. Cumerford men have their feet right smack on the ground.

"They spent our campaign money as if it were coming out of their own paychecks. I can't recommend this firm highly enough.

"Why don't *you* talk to the Men at Cumerford about raising the money?"

The men of Cumerford are at work now in churches, colleges, and hospitals across the country, raising the funds for new facilities and new buildings.

If you are thinking of raising funds for capital expenditures, operating expenses, or starting programs in the related fields of public relations, you would be wise to talk to the Men at Cumerford now.

"Write or call The Cumerford Corporation, 912 Baltimore Avenue, Kansas City 5, Missouri. Telephone BAltimore 1-4686. An appointment at your hospital or if you prefer, in our offices will be promptly arranged at no obligation.

SOME OF THE MANY INSTITUTIONAL SERVICES PERFORMED BY THE MEN OF CUMERFORD

Municipal Bond Issue Promotion
Boy Scout Campaigns
Institutional Fund Research Studies
Community Chest Drives
YMCA-YWCA Capital Programs
Hospital Consulting
College & University Fund-Raising
Alumni Programs
Long-Range Development
Capital Fund Campaigns
Wills and Bequests
Institutional Public Relations
Salvation Army Fund-Raising
Church Building Campaigns
Geriatric Institutional Programs
Institutional Annual Reports
Art Institute, Museum Campaigns

For additional information, use postcard facing Cover 3.

new McKesson

'1200' absorber

sets new high standard for compactness and efficiency . . . and will fit any regular anesthesia unit!

Several salient features of the new McKesson '1200' ABSORBER

- twin vertical reversible *acrylic* canister instantly removable by loosening single clamp screw
- screens easily removed by loosening bayonet-type connection
- newly-designed silicone-rubber valves have low adhesion properties, are extremely quiet in use, and seal perfectly
- valves mounted in acrylic caps, instantly removable without tools
- provides 30 to 40 hours of absorption . . . extremely low resistance to respiration

McKesson '1200' ABSORBER

Write for '1200' Absorber Brochure. This complete information is yours for the asking by letter or postcard.

McKESSON APPLIANCE COMPANY • TOLEDO 10, OHIO

Procter & Gamble announces

for hospital use!

More than just a soap, Zest washes away skin bacteria while leaving skin cleaner than any ordinary soap can!

Zest is Procter & Gamble's totally new kind of bath bar that's ideal for hospital use. Sold only as a wrapped bar, Zest offers the ultimate in hygienic care of patients. Its new cleaning action leaves skin cleaner, clearer—completely free of sticky film. Zest's new effective deodorant action helps patients feel comfortably fresh all day long after a bath. And equally important, Zest's mildness is gentle on skin made tender by long confinement in bed. Your staff and patients will welcome the change! Order Zest today from your supplier. Or just write to:

Procter & Gamble P. O. Box 599, Cincinnati 1, Ohio

you'll always buy stainless steel

Add the low yearly maintenance cost to the initial price.

Then, divide the total by the *many years* of active service you enjoy with stainless steel.

RESULTS: YOU SEE THAT SHAMPAINE STAINLESS STEEL EQUIPMENT COSTS YOU LESS THAN ANY OTHER TYPE

a SHAMPAINE industry

Shampaine COMPANY

1920 S. Jefferson St. Louis, Mo.

THE WORLD'S MOST COMPLETE LINE OF STAINLESS STEEL SURGICAL EQUIPMENT

SHAMPAINE MULTI-LINE BASSINETS

- Four basic groups . . . 19 variations include—
  - Single or double storage compartments
- Side or end-opening drawers
  - Drop-leaf or pull-out shelves

. . . In Silverlux, pink, blue enamel or stainless steel

Shampaine COMPANY

1920 S. JEFFERSON • ST. LOUIS, MO.

• SHAMPAINE Industry

THE WORLD'S MOST COMPLETE LINE OF NURSERY EQUIPMENT

For additional information, use postcard facing Cover 3.

In noise control...the big news for 1959 is ***Panelglas—***

a product of JOHNS-MANVILLE FIBER GLASS

With L·O·F Glass Fibers Company joining the J-M family, your Johns-Manville acoustical contractor can now offer you Panelglas, the new "lay-in" ceiling panel made of J-M Fiber Glass.

Panelglas soaks up as much as 90% of the sound waves that strike it. Large 2 ft. x 4 ft. panels fit neatly and squarely into a simple suspended grid system. They are easy to put up—equally easy to remove for access to overhead fixtures. Panelglas panels stay smooth and rigid—make a handsome slightly textured, light-reflecting ceiling.

Quell distracting noise. Step up working efficiency. Put up a ceiling of sound-deadening, good-looking Panelglas. To get all the details, write to Johns-Manville, Box 158, New York 16, N. Y. In Canada, address Johns-Manville Company, Limited, 565 Lakeshore Road East, Port Credit, Ontario.

Panelglas joins the famous J-M Acoustical Products

- *SANACOUSTIC®*
- *PERMACOUSTIC®*
- *DRILLED MINERAL TILE*
- *FIBRETONE®*

JOHNS-MANVILLE

JOHNS MANVILLE JM PRODUCTS

Staff morale is better since our hospital was color styled

Our staff has an entirely new outlook since Pratt & Lambert helped us re-style the hospital interior with Calibrated Colors®.

It's amazing how attitudes and work habits change for the better when environment is improved. Patients and visitors remark about the beauty of our new look.

Beauty is just part of the Pratt & Lambert story. Scrubbable Pratt and Lambert wall coatings are easy to keep looking like new ...woodwork and trim painted with Pratt & Lambert enamels will take all kinds of abuse. Frequent repainting just isn't necessary when you use Pratt & Lambert products.

Hospital maintenance men, who use Pratt & Lambert Paints and Varnishes consistently, say that no others go on so easily, look so well, last so long.

Why not find out how fresh color styling can improve your hospital...how P&L can help you cut maintenance costs, too. Clip the coupon.

New Lyt-all Flowing Flat gives long-lasting beauty to reception rooms, corridors, wards, rooms, every wall and ceiling in your hospital.

PRATT & LAMBERT-INC. Dept. 1
75 Tonawanda St., Buffalo 7, N. Y.
In Canada: 234 Courtwright St., Ft. Erie, Ontario

- ☐ Please send me free color cards.
- ☐ I would like color suggestions by an experienced Pratt & Lambert representative.

Name .....
Address .....
City ..... Zone ..... State .....

PRATT & LAMBERT-INC.

A Dependable Name in Paint Since 1849

NEW YORK • BUFFALO • CHICAGO • FORT ERIE, ONTARIO

taste the quality

Nature hid 7-Up's unique flavor inside the *peel* of fresh lemons and limes. There, in minute quantities, a fragrant essence is produced. It is this essence which penetrates the "meat" of citrus fruits—gives them their clean, tangy taste.

Twist a peel near a candle flame. The barely visible mist bursts into light. You "see" the same natural fruit essence which 7-Up extracts using special equipment. From this, 7-Up refines and selects only a tiny fraction—the very best—to make its flavor concentrate.

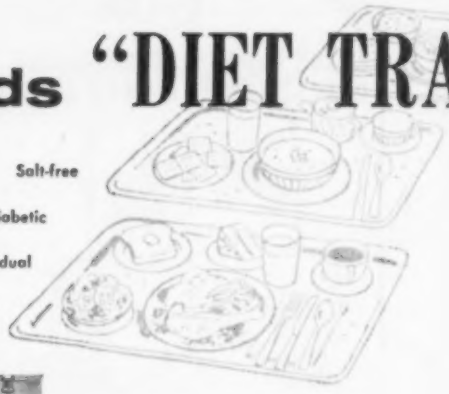
To produce *1 ounce* of concentrated 7-Up flavor, the peel of *hundreds* of fresh lemons and limes is used. Truly, 7-Up is Nature's own gift . . . a pure, wholesome, natural flavor—quality you can taste . . . quality you can trust.

Nothing does it like Seven-Up!

important FOOD SERVICE news

The all new Nutting FOOD-*ala*-CART® System

ends "DIET TRAY CONFUSION!"



Here for the first time is a food service system that ends one of the biggest problems facing dietitians . . . "Diet Tray Confusion." FOOD-*ala*-CART is the first and only food service system to provide *one oven drawer* for *every serving tray!*

This exclusive FOOD-*ala*-CART feature ends "Diet Tray Confusion" and makes spot checking easier — more accurate. It also speeds tray assembly — makes it simpler.

PATENT APPLIED FOR

Dietitians who have seen the FOOD-*ala*-CART system say it's the easiest to use equipment they have ever seen. Its design is based on a comprehensive research study among dietitians. These dietitians told us it's not the fixing of the food but the serving that is the big problem. The Nutting FOOD-*ala*-CART answers the serving problem best because it simplifies it, ends "diet tray confusion," keeps foods appetizing, refreshing, delicious tasting right to the patient. It is truly *the new standard of fine food service for hospitals.*

Only the new FOOD-*ala*-CART system offers *all* these features!

- ONE OVEN DRAWER FOR EVERY SERVING TRAY ends "diet tray confusion." It's the easiest to use food service system you have ever seen.
- FROZEN FOOD SECTION keeps frozen desserts served in sliced form, in ramekins or similar containers frozen; even ice cubes won't melt.
- ALL FOODS are served at dietetically accepted temperatures for maximum patient "meal appeal."
- VERSATILE INTERIOR — Easily changed to accommodate 3 different tray sizes; no tools are needed. Can also be changed to handle from 16 to 24 trays. Interior can be easily and entirely cleared for steam cleaning.
- ROLLS EASILY — Large ball-bearing wheels with non-marking rubber tires especially compounded for easier starting, easier rolling.
- COMPACT SIZE makes FOOD-ala-CART easier to handle. Clears any hall, door or elevator opening.
- SAFER — Center hung door panels do not extend beyond cart when open.
- EASIER TO USE — EASIER TO SEE CONTROLS — There's no guesswork about this cart. All controls are up in plain sight, easy to see. Simple switches turn "ON" and "OFF". Refrigeration and heat controls are pre-set — require no adjustment by user.

Everyone is happier with FOOD-*ala*-CART! Patients, physicians, nurses, aids *and* dietitians, *all* like the way FOOD-*ala*-CART eases preparation, keeps foods appetizing and simplifies serving.

FOOD *-ala-* CART
HOT COLD
THE WELL BALANCED FOOD SERVICE SYSTEM

Nutting
TRUCK AND CASTER COMPANY
Faribault, Minnesota
Since 1891

Write today for FREE FOOD-ala-CART Brochure!

FOOD-*ala*-CART
Nutting Truck and Caster Company
1040 Division Street, Faribault, Minnesota

Without cost or obligation, please send me latest information about FOOD-ala-CART.

Name_____

Name of Hospital_____

Address_____

City_____ State_____

WILL ROSS, INC.

is pleased
to announce
the opening of
its newest
warehouse

strategically located for better service
to Eastern hospitals . . . at less cost

See your Will Ross, Inc. representative soon

WILL ROSS, INC. MILWAUKEE 12, WISCONSIN

Atlanta 3, Georgia • Baltimore 30, Maryland • Cohoes, New York
Dallas 7, Texas • Minneapolis 14, Minnesota • Ozark, Alabama

Manufacturers and Distributors of Hospital and Sanitorium Equipment and Supplies Since 1914

SMALL HOSPITAL QUESTIONS

Use Too Much Linen?

Question: A study of our linen consumption and laundry operations indicates we are using approximately 16 pounds of linens per patient per year, and are turning over our entire linen supply once every three years. One of our trustees, who is in a related business, considers this usage excessive. What is the experience of other hospitals? – E.N.C., Ind.

ANSWER: The experience of other hospitals would indicate your linen consumption is economical rather than excessive. Your consumption is at the lower end of a scale that may run to as much as 20 or 22 pounds per bed per year in some hospitals, and in some cases the entire linen inventory is replaced annually, instead of every three years as in your case, though admittedly the annual turnover would appear excessive.

Cost of Drugs

Question: Many patients feel drug charges are very much out of line; usually they make a comparison of the hospital's drug charge with what they might pay for the same drugs at their drug stores. Of course, anyone connected with a hospital understands why drug charges must be as high as they are, but we feel the need for an explanation to offer the public. Like most others, we charge more for drugs than is absolutely necessary, in order to keep our room charge from becoming unacceptably high. So we must have a satisfactory explanation to offer our patients, in addition to the information already provided in our public relations pamphlet. Can you furnish something that might be useful in the solution of this problem? – R.A.L., Kan.

ANSWER: There isn't any satisfactory answer to this question. Some patients will accept the explanation that the charge for giving drugs in the hospital must be higher than the charge for the same drug purchased at retail because the hospital must bear the expense of the nurse who administers medications, pharmacy, floor records, and so on, but most people will understand quickly that these costs by no means account for the entire difference, and they will properly conclude that the hospital is making a profit on drug charges.

You can explain that any such "profits" are used up in the charges for room, board and general nursing care that are priced below cost, when the question is raised directly by an individual patient–but it might not be wise to treat this whole subject in pamphlet form, for general distribution.

Short of "pioneering" in the establishment of all individual service charges in direct relationship to costs, there is no answer to the problem of drug charges that can be found in any public relations technic. Many public relations advisers suggest a policy of not answering questions that haven't been asked; thus instead of printing a pamphlet on this subject, the hospital would do well to wait until the question is asked specifically, and answer it frankly and honestly, explaining the hospital's cost-and-charge dilemma.

Heating for TB Hospital

Question: We are a 52 bed tuberculosis hospital with an oil burning, steam heating system operating at 90 pounds pressure. We heat our hot water by means of a steam coil in a 1000 gallon copper hot water storage tank. The tank has been condemned, is not repairable, and must be replaced, which will be a costly installation. We are considering, from an economical point of view, the installation of an instantaneous water heating system using a steam heating coil with a capacity of 28 gallons a minute, a reduction valve to reduce steam pressure to 25 pounds, a steam trap with a copper storage tank of 100 gallons capacity to carry us through the summer nights for emergency purposes when the steam boiler is closed down for the night. Could you please advise us if this hot water heating system would operate satisfactorily and, at the same time, be adequate for our needs? – H.F.S., N.Y.

ANSWER: This inquiry was referred to Richard P. Gaulin, mechanical engineer, Division of Hospital and Medical Facilities, U. S. Public Health Service, who has replied as follows:

This office recommends the following quantities of water for tuberculosis hospitals: 6⅝ gallons at 125° F. per hour per bed for hospital fixtures; 4 gallons at 180° F. per hour per bed for kitchen; 2 gallons at 180° F. per hour per bed for laundry. A total of 12⅝ gallons per hour per bed is required. Assuming you operate your own laundry, your water heater should have a capacity of 650 gallons per hour. With this heater, we would recommend a 500 gallon storage tank.

For nighttime operation in the summer, we suggest you might investigate the use of a small gas or electric storage water heater to meet your estimated needs. With reference to the system you propose, we offer the following comments:

1. We would hesitate to use an instantaneous water heater because of peak demands, such as occur in the morning with bathing, kitchen and laundry loads occurring simultaneously.

2. We do not believe a 100 gallon storage tank, however well insulated, would maintain temperatures during the nighttime. Any drawdown from the tank would immediately be replaced by cold water, which would reduce temperature in addition to the heat loss through the insulation.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

THE VAST MAJORITY OF THE NATION'S FINE BUILDINGS ARE SLOAN EQUIPPED

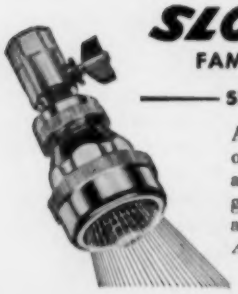
New Headquarters Building
WARREN PETROLEUM CORPORATION
Tulsa, Oklahoma

PHOTOS © EZRA STOLLER

SKIDMORE, OWINGS & MERRILL
architects and engineers
W. R. GRIMSHAW COMPANY
general contractor
WATT PLUMBING & ELECTRICAL CO.
plumbing contractor
PLUMBERS SUPPLY COMPANY
plumbing wholesaler
AMERICAN RADIATOR & STANDARD SANITARY CORP.
fixture manufacturer

UNUSUAL DESIGN HIGHLY PRAISED

•A most unique feature of the new Warren Petroleum building is a balcony surrounding each upper floor. The structural walls are windowed with sealed glazing. The floor slabs extend 5 ft. beyond these walls to where vertical aluminum I-beams support 40 in. visors of gray, heat-retarding glass placed at ceiling height. A terrace of travertine and granite connects the main building and a large cafeteria which roofs a lower level garage and service area. Exteriors here are of polished aggregate precast concrete trimmed with aluminum and glass. Interiors throughout are air conditioned and are distinguished by the use of natural materials and neutral colors. As are thousands of other praiseworthy buildings, the new Warren Petroleum headquarters building is completely equipped with SLOAN *Flush* VALVES, famous for efficiency, durability and economy.



SLOAN *Flush* VALVES
FAMOUS FOR EFFICIENCY, DURABILITY, ECONOMY
SLOAN VALVE COMPANY • CHICAGO • ILLINOIS

Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects and Engineers specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

Write for completely descriptive catalog

wire from Washington

PROGRESSIVE CARE REPORT

In an interview based on a report scheduled for release by American Hospital Association, Dr. Jack C. Haldeman, chief, Division of Hospital and Medical Facilities, P.H.S., said more than 100 general hospitals have elements of progressive patient care in operation, and 22 hospitals have special facilities constructed for progressive care.

The P.H.S. survey showed that 395 general hospitals are planning to adopt some elements of progressive care, Dr. Haldeman told *Scope Weekly*.

Because cost of providing service in intensive care areas is greater than the cost of ordinary care, Dr. Haldeman said progressive care probably would not reduce the total cost of hospitalization to patients.

The maximum number of intensive care patients that should be assigned to a single nursing team is six, the P.H.S. study indicated, and the minimum size for self-help units is 12 beds.

HOSPITALS IN POLITICAL SQUEEZE

Hospitals may be caught in a political squeeze that could cost them as much as $45 million next year in new taxes. Later the figure would go down, but it is estimated the permanent annual cost would not drop below $12 million.

At stake is legislation to extend unemployment compensation coverage to all private nonprofit organizations, with hospitals the largest single group affected. Because an "experience factor" is applied after the first year – which reduces costs for organizations with steady employment records – there would be later downward adjustments.

In this situation the hospitals are caught between liberal and conservative factions from both parties.

Liberal Democrats, with the support of many like-minded Republicans, are pushing hard for the compulsory extension of federal unemployment standards to all states. They are opposed by a much smaller, also bipartisan, band of conservatives.

Not wishing to join with either side, the Eisenhower Administration has come up with its own in-between proposal – let the states continue to set their own standards, but make coverage compulsory for all private, nonprofit organizations. That largely means hospitals.

At hearings before the House ways and means committee, the American Hospital Association was the sole spokesman for the opposition. Frank Groner, A.H.A. trustee and administrator of the Baptist Memorial Hospital of Memphis, was the witness. Among his points:

1. Because hospitals have so little unemployment, the principal effect of the new law would be a heavy tax burden on hospitals. Even if their costs were reduced to the legal minimums, they still would be in a position of subsidizing industries with high rates of unemployment. It was pointed out that even in the depths of the depression, when unemployment compensation systems were born, hospitals could demonstrate they had so little unemployment that they were not included.

2. Hospital wages are rising, but they still are inadequate in competition with private industry. Therefore, any extra money in hospital resources should be applied to wages.

3. It is wholly appropriate that hospitals pay social security and workmen's disability compensation taxes, because hospital workers are subject to the same old-age, death and injury risks as other employes. But they are not subject to the same layoff risks.

4. If forced to pay unemployment compensation taxes, private, nonprofit hospitals would be discriminated against in favor of government hospitals, which would not be brought under coverage by this law.

5. There would be only one place for the hospitals to get the money to meet the new tax load – increase their charges to patients.

Among the witnesses, the principal supporter of the bill was Labor Undersecretary James P. O'Connell, who argued that private, nonprofit organizations should line up with other employers and make unemployment taxes an essential part of their budgets, the same as, say, fire insurance costs.

With hearings ended, the committee is making its decision behind closed doors. If the bill clears the committee and the House, it still will have to pass the Senate. But there is plenty of time – unless voted down, the bill will remain alive for the rest of this session and all of next.

INSURANCE FOR U.S. CIVILIAN EMPLOYES

The question of a national program of hospital-medical insurance for U.S. civilian employes, which has been on and off the track for more than six years, is building up new steam, but some of the same old danger signals can be seen ahead.

Hearings were held before a Senate subcommittee of which Sen. Richard Neuberger (D.-Ore.) is chairman. Other members are Senators Ralph Yarborough (D.-Tex.) and Thruston Morton (R.-Ky.), new national G.O.P. chairman.

Six years ago President Eisenhower proposed a broad program of health insurance for U.S. employes; it failed because the groups affected couldn't get together on what they wanted. Subsequently the Administration offered a program that included catastrophic coverage, for which the U.S. would pay the full costs. It failed for the same reasons.

The bill now up for action is sponsored by Sen. Olin Johnston (D.-S.C.) and Rep. James H. Morrison (D.-La.). It provides that the government pay two-thirds of the cost of basic coverage, with the employe permitted his choice

of plans and given the right to change plans yearly, and major medical insurance, with U.S. paying the total cost of the latter.

Because of the demonstrated interest of the White House in this issue, the Administration is not openly opposing the bill, and in fact is pleading that it be modified enough to make it acceptable.

Acting for the Administration, the Civil Service Commission is opposing four points:

1. It believes the cost, $350 million a year at present employment levels, is too high.

2. It believes a new program of this nature should not take on the heavy burden of insurance for retirees, as would the Johnston-Morrison bill.

3. It feels that two-thirds of the cost of basic insurance is too much for the U.S. to carry, in addition to full costs of major medical insurance, and asks that the government's share be dropped to the one-third provided in an earlier Administration bill.

4. Because of the overhead costs, it objects to the provision allowing an employe to shift basic policies annually if he so wishes.

Although all are proposing some changes, the plan has the general endorsement of Blue Cross, the Blue Cross Association, commercial companies and federal employe unions.

How close to agreement these groups really are won't be determined unless and until the committee decides to report out the bill. If this time they are as insistent on the "changes" as they have been in the past, the legislation faces the same old fate.

For example, one suggestion is that all hospitalization charges be handled by Blue Cross, but that Blue Shield compete with commercial companies for the surgery phase, a proposal that is not likely to engender much enthusiasm in the latter.

HEARINGS ON BLUE CROSS

At this writing (late April) no date has yet been set for the start of hearings by Sen. Wayne Morse's subcommittee on Blue Cross-Blue Shield costs in the District of Columbia. But the hearings definitely will be held.

Meanwhile, there is assurance that the hearings will not be dull. The subcommittee staff has spent some time looking into the financial relationships between hospitals and their professional employes, mostly radiologists, in the Washington, D.C., area.

The staff also has made extensive studies of state sponsored hearings in Pennsylvania, Maryland and New York on reasons for increases in Blue Cross-Blue Shield rates.

The investigation is under the auspices of the Senate district (of Columbia) committee. Should the hearings develop interesting enough material, Senator Morse is prepared to ask a nationwide study by the labor and welfare committee, of which he is also a member. (See page 97.)

MEDICAL CARE OF THE AGED

The two-month delay by the Department of Health, Education, and Welfare in publishing its intensive study on medical care costs of the aged stirred up considerable speculation and uncertainty. Now that it is released, the uncertainty remains, as does the big question: Is the Administration going to support the Forand bill for hospitalization under social security?

While indicating that the federal government shouldn't get into a field where its help is not definitely needed, the report lays down these "yardsticks" for evaluating the problem:

1. A great majority of the elderly have low incomes and small resources.

2. No more than two out of every five of them have private health or hospitalization coverage of any sort, and what they have is generally meager and uncertain.

3. For the first year payments to hospitals would be about $904.9 million, and for surgical and medical care about $80 million.

Instead of making recommendations for the Forand bill or an alternative — or for no federal action — the report merely lists reasons the U.S. should get into this picture, and reasons it shouldn't.

It may be that this fence-straddling, if that is what it is, will prove to have been a waste of effort. H.E.W. Secretary Flemming, shortly after publication of the report, announced flatly that at a later date he would make specific recommendations to Congress, based on the report.

Whatever interpretation the Administration puts on the study, those working for the Forand bill were quick to embrace it.

Rep. Aime J. Forand (D.-R.I.) said it confirmed what he had been saying for a long time, namely, that the problem of paying old people's medical bills is so big it can't be solved without intervention of the federal government. President George Meany, whose A.F.L.-C.I.O. has given the Forand bill strong support for years, described the report as "overwhelming evidence we cannot afford" to delay federal action.

American Medical Association, which has led the fight against the social security hospitalization bill, was officially silent, pending a careful study of the report. It was known, however, that some A.M.A. staff people believe the facts in the study will strengthen more than weaken the association's position.

The American Hospital Association, technically (but not violently) opposed to the Forand bill, had nothing to say for the time being.

New York Hospitals Face Walkout

NEW YORK — A strike against six New York hospitals was scheduled for May 8 by Local 1199 of the Retail Drug Employes Union.

The walkout was called after 70 of New York's 81 voluntary hospitals rejected a proposal for a fact-finding committee that would conduct a thorough investigation of all issues involved in the labor dispute.

On May 7 five of the six hospitals threatened with the strike sought an injunction in the state supreme court to bar the walkout. The sixth hospital, Jewish Hospital of Brooklyn, obtained a court order delaying the walkout until May 11. Hospital and union representatives have refused to meet face to face during the discussions and conferred through city labor commissioner Harold A. Felix (see page 140).

The Modern Hospital
MAY 1959

LOOKING AROUND

Wanton, Reckless Law

RECENTLY we had an opportunity to read the complaint filed by plaintiff's attorney in a malpractice suit against a hospital, and we were shocked, as we have been before, at the language. The case was one of those nightmares of mistaken identity; the wrong patient had been taken to the operating room and anesthetized, and the operation had barely begun when a flash from the nursing floor, where the right patient had been discovered fretting about the "delay" in his operation, stopped the surgeon, literally, with his knife in mid-air.

As it must in such cases, the hospital acknowledged negligence on the part of its employe, in this case a nurse's aide, who failed to make the proper identification. But there was a question, at least, of contributory negligence on the part of the plaintiff, an elderly man who answered three times to the wrong name during the episode. Moreover, repeated medical examinations of the plaintiff revealed that, while an incision was begun, with the exception of some anguish and inconvenience, freely admitted by the hospital, no real damage was suffered.

But what does the complaint say? The complaint charges that the aide, the floor supervisor, the nurse in charge of the operating room, the anesthetist and the surgeon were guilty of "wanton, reckless and wrongful assault" on the patient! These words are repeated three times in the complaint, which seeks some $50,000 in damages from the hospital and the surgeon.

We asked a lawyer friend why it was necessary, in a case of negligence which has caused the hospital and its employes, and the surgeon, at least as much anguish as it caused the plaintiff, to claim wanton, reckless assault when it is perfectly plain to everybody, including the plaintiff and his attorney, that no wanton, reckless assault occurred within the meaning of these words as everybody over eight years old understands them.

It was a legal maneuver, our friend explained, similar to that of the prosecutor who charges murder hoping for a conviction of manslaughter, or, perhaps, comparable to the tactic of the batter who berates the umpire for a called strike, seeking to influence the next close call in his favor. "A complaint charging wanton, reckless assault would be more likely to induce the hospital to a favorable settlement," our friend said, "or, if the case went to court, it might be expected to make the jury take the evidence against the hospital more seriously, with a resulting verdict in favor of the plaintiff."

Not if we were on the jury, it wouldn't! If we were on the jury, we'd vote to throw any lawyer who called simple negligence "wanton, reckless assault" out of court, and we think all juries and judges should do the same. If wanton, reckless language is a proper legal maneuver, the law is not only, as Mr. Bumble said, "a ass, a idiot." It stinks.

Leaders and Managers

FOR reasons that were never wholly clear and are unimportant here anyway, we found ourselves not long ago attending and taking part in a week-long seminar on management at a luxurious mountain retreat that was once a millionaire's estate and is now, for the usual cause, the property of a university. The university's school of business administration keeps the place filled most of the time with business executives ingesting massive doses of management logic, mountain air and Beaujolais — a combination that is wholesome tonic for the spirit, if not for the waistline.

As hospital administrators have learned in their own graduate schools, seminars and institutes, there is a definitive body of knowledge about the principles and processes of management. Like many of the hospital administration meetings we have attended as a reporter, this seminar was concerned with the body's musculoskeletal structure — the principles of planning, organizing, directing and controlling, and with its heart and great vessels — the processes of decision-making, motivating and communicating.

Under the guidance of a teacher who had the strength of character to refrain from giving the answers and the skill to compel students to seek answers within themselves, we examined the principles and processes first as abstractions, then sought to apply them in given business cases. The latter exercise, inevitably, laid bare all the traps that are familiar to experienced administrators: the failure to delegate because it's easier to do it yourself; the uneven distribution of responsibility and authority; the unwillingness to observe proper channels once they are established; the deci-

sion that doesn't foresee all the consequences; the tendency to see things as they should be and not as they really are; the temptation to master-mind; the inconsistencies of rewards and penalties; the reluctance to tell others what is going on upward in the administrative hierarchy and to find out what is going on below.

Unquestionably, examining the management processes and circling around the management traps can be a revealing experience for business executives, and even for editors, as it is for hospital administrators, but we were impressed increasingly as the week rolled on and the words rolled out that management is still more art than science and good performance demands more of character than of knowledge. A great deal of what we heard about direction and motivation and communication could be summed up simply in the words of Ecclesiastes: "Better is it that thou shouldst not vow, than that thou shouldst vow and not pay."

It was not in its precepts or discourses, however, but in its own functioning that the seminar offered the most instructive lessons in the art of administration. The group leader was essentially a man who listened and inquired, leading by low-keyed persuasion rather than by high-powered authority. At the end of the first hour, it is doubtful that any man in the room would have hired him; at the end of the week, it is doubtful that any man in the room wouldn't have been glad to work for him. The qualities of leadership are harder to define and analyze than are the processes of management, but the true leader can always throw away the book and succeed as a manager, and the manager who is not also a leader may obey all the rules and still fail.

The fact of the matter is that the way our society is organized, many are forced into roles as managers who have neither taste nor talent for leadership. Fortunately, this inadequacy can be compensated to some extent by knowledge of the management process — and above all by self-knowledge, and if he clings to the former and improves the latter consistently enough and long enough, the manager's performance may be satisfactory or even, eventually, superior. For most men, however, the human need to be loved may be a fatal tear in the managerial fabric. We want to be nice fellows, and nice fellows say "yes" or "maybe," or "tomorrow," or "if" — when the only right and honest thing to say is "no." What we lack is courage, and courage isn't found in books or seminars. It is found in leaders.

Bright Side

VISITING with hospital people at the spring conventions this year, we sensed that they were deeply hurt by the article about hospitals that appeared in *Look* magazine last winter. In a way that previous articles of the same *genre* failed to do, the *Look* article caused bitter resentment.

Well, we can certainly understand why this is so, and we have nothing to add to what has already been said about the *Look* article, which may easily have been the most widely discussed document since the Dead Sea Scrolls. What we want to point out instead is that hospitals still have an overwhelmingly favorable press — something few hospital administrators, apparently, have stopped to consider. Our newspaper this morning, for example, carried a page one picture taken in a hospital emergency room, where a nurse and two doctors were busy attending the needs of an accident victim. Every day, newspapers all over the country print hundreds such stories; every such story tells millions of readers, "Hospitals get you well when you are hurt." Magazines abound with articles describing new medical technics and scientific developments; without exception, the locale of these articles is the hospital. Books roll from the presses telling similar stories of accomplishment and hope. One of the latest of these is a 277 page paean to the skill and devotion of the surgeons and nurses at one hospital and, in fact, to the whole history of surgical development in hospitals in our time.*

But hospital people forget the paeans and dwell broodingly on the jeremiads instead. We were reminded of this not long ago when we attended a meeting of public school administrators, where we fell to talking about the public relations problems of schools.

"What can we do to offset the effects of all these terrible, critical articles about schools that are appearing in newspapers and magazines?" the school people wanted to know.

"That's just what the doctors and hospital people keep asking," we replied.

"Doctors and hospitals?" the school people said in astonishment. "Why, doctors and hospitals have a marvelous press!"

So they do — and so, on balance, do the schools.

*The Operation, by Leonard Engel. New York: McGraw-Hill Book Company, Inc. 1958.

Question

SURGEONS may quarrel with the implications of a clinical report that was presented at the scientific assembly of the American Academy of General Practice last month, but philosophers will applaud the method. Dr. Louis T. Palumbo, professor of surgery at the State University of Iowa College of Medicine, reported that surgical wounds healed as quickly and uneventfully when bandages were removed entirely within 24 hours as they did when conventional treatment was followed, with bandages continued up to eight days.

Dr. Palumbo's report covered treatment of 222 incisions; in 111 cases, the conventional method was followed, with 90 per cent of the bandages removed by the end of the eighth day following surgery. Bandages were removed from the other 111 incisions at various times — some within six hours, more than half within 24 hours, and all within 48 hours. Complications were minimal and almost identical in both groups, it was reported, and the surgeon added that the unbandaged incisions appeared to heal faster, with less local inflammation and no adhesive irritation. Moreover, it was reported, none of the patients objected. On the contrary, most of them were eager to watch their incisions heal; curiosity obviously outruns fastidiousness.

With rising rates of surgical wound infection in many hospitals and emphasis on the hazards of air-borne infection today, not many surgeons will be likely to follow Dr. Palumbo's lead, and, indeed, in many hospitals it might be hazardous to do so. But the method is one that could be applied to advantage, unquestionably, on nursing floors and elsewhere throughout most hospitals.

The method is simply to ask, not "Why do we do it this way?" but "Why do we do it at all?"

In this analysis of the basic conflict between a fighter pilot and his organization, the author finds a close analogy with the conflict between doctor and hospital – and for the same reasons

The Only Team That Pilots – and Doctors – Recognize Is Their Own

David M. Kinzer

David Kinzer, executive director of the Illinois Hospital Association, was a navy dive bomber and fighter pilot during World War II. He did graduate work in journalism at Northwestern University and in sociology at the University of Stockholm, Sweden. He has been assistant editor of Hospitals, *staff writer for the American Dental Association, and public relations director of the Commission on Financing of Hospital Care.*

DURING the second world war I flew in the Navy off aircraft carriers. We were called the Air Group. It included three squadrons — fighters, dive bombers, torpedo bombers. The squadrons broke down into wings, divisions, then sections. The two-plane section was the smallest unit of aerial command.

All of this was laid out neatly on the organizational chart. Within the squadron the line stairstepped up to the squadron commander, or skipper, who reported to the air group commander. The air group commander's line stretched horizontally, then vertically without break up to the executive officer and captain of the ship. In other words, the air group was on a line with all the other command departments of the ship — Navigation, Operations, Engineering, Gunnery, Air. The Air Department, as distinguished from the Air Group, was responsible for all the services and maintenance of aircraft. It should be noted that the air officer, with responsibility for the planes, and the air group commander, with responsibility for the pilots, were equals in the line of command, with neither in a position to order the other around.

Looking at the organizational chart, you would say at once that this was the orthodox line and staff organization and that the air group was an integrated, functioning unit of the ship. There was plenty of evidence to indicate that the high Navy brass of those days thought so, too.

But this was another organizational chart that concealed much more than it revealed. The group most responsible for divorcing it from reality was the pilots.

This chart was one of the things, among many others, the pilots of those days labeled as "strictly oatmeal."

We knew, you see, that this was *our* ship. It had been created for us. Obviously, therefore, the officers and crew of the ship were in our service. If

they weren't they belonged on shore. In our minds, these points were beyond argument, as changeless as revealed truth. We weren't helping the ship carry out its mission; the ship helped us carry out ours. After all, what good was an aircraft carrier without pilots?

Does this sound like anything you've heard before?

Pilots Were Set Apart From the Rest of the Ship Because They Were Geared to the Demands of Their Calling — Sound Familiar?

We weren't at all impressed by the ship's organization, probably because we rarely thought of it as such. To us it was a place to land, a kind of floating service center where all the details incidental to our missions were accomplished. The ship therefore had to gear itself to us. The ones that accommodated themselves to us most swiftly and efficiently were the best ships.

> ***The fact that they all made a try at doing this only served to confirm our point that the chart was just another piece of Navy paper. With the pilots' interests in mind, the Navy had applied an overlay of special privilege that almost concealed the ship's formal organization. For instance, our ready rooms were the only spaces aboard with air conditioning, except for the captain's quarters. A meal was always available to us, but not to other officers, on the off hours. We were the only ones that could get legal "drinking whiskey." A pony bottle of brandy, a good jolt, was served up to us after each strike.***

We were the only officers that weren't obliged to stand a ship's watch. The ship's day was split into these equal segments and its officers and crew were parceled out so that the ship's operations were fully covered at all hours. But our day was not the ship's day. It was never that predictable. They couldn't occupy us with routines, because we had to be ready to scramble for our planes on very short notice. So we did a lot of waiting. Often we did our waiting in the sack in wardroom cabins. That was another privilege. If a pilot was found in the prone position during general quarters, it was because he was tired. Any other officer so occupied would have been up for court martial. The pilots, in fact, could be counted on to break even the most rational of Navy regulations with regularity. We were unquestionably the sloppiest group aboard ship. Anyone who had seen a Navy crew at sea knows this is quite a distinction. It used to amuse us when senior career officers would suddenly be confronted with one of our unkempt and unshaven pilots. He would turn his head, pretending he hadn't seen him, and walk the other way.

We were convinced, though, that the privileges of perpetual readiness were more than offset by the responsibilities. Sometimes it meant taking off so late we had to land by night, or else taking off so early that we had no horizon as we mushed off the end of the deck. Sometimes it meant long stretches of furious, rushing activity without sleep. The hard part about these periods and what made them so exhausting was that, all the way through, you never felt you could let yourself make a mistake.

While we were never happy about this aspect of the carrier pilot's life, we were, to the last man, proud of it. This, we were convinced, was the ultimate reason why we were set apart (and above) the ship's organization. The rest of the ship, we said, was geared to the clock; we were geared to the demands of our calling.

And doesn't this have a slightly familiar ring, too?

They Were Members of a Tight and United Community — the Most Select, the Most Needed, the Most God-Gifted of All Men

From our first days as cadets the unique status of pilots was drummed into us. Though the Navy had put us on a salary, we were appeased by flight pay, which gave us 50 per cent more money than anyone else of equal rank or grade. Our appetites were whetted by a big publicity program. Pilots were made the personification of a mighty and air-minded Navy. When the press agents wrote about great victories, it was the pilot who sank the ship or shot down five of the enemy in one dogfight. They didn't bother too much about the guy who had loaded the guns.

The publicity also stressed that Navy cadets were the few chosen from the many. Even when selection standards had to be relaxed, they publicly held to this line. It not only had recruitment value; it was also designed to motivate the fledgling pilot himself. They had to make us feel privileged and select to make us equal to the kind of training program they had laid out.

They really put it to us. We had to learn jujitsu and trigonometry and other subjects that later seemed only remotely related to the business of carrier aviation. The discipline was sadistic. Even the enlisted men abused us. The one overriding objective seemed to be the shattering of our confidence.

In the early stages, our flight instructors usually told us frankly that we were hopeless. Each additional instructional period was granted as if it were a reprieve from ultimate-

ly certain execution. Once you got to the point where you could do a fairly decent landing or loop, then they'd start telling you that just learning how to fly didn't mean you could make the grade as a Navy pilot. Flying the airplane was only about 50 per cent of it. The remainder was, as one of them put it, "dedication." You had to want to do it, because even in the fleet no one could really make you do what had to be done. As they put it, we were the ones, the only ones, who could "deliver the goods."

There was one instructor in particular, a tough old flying chief from the peacetime fleet, who terrorized everyone. He used to ask us technical questions on the engine or the guns that weren't even covered in the curriculum. When we couldn't answer them, he was off on a tirade about the new generation of pilots. The moral of his story was that you couldn't count on any mechanic or plane handler to do anything right unless you knew what "right" was and made sure they knew it. "Don't trust the ship too much, Sonny," he would say. "It isn't your damn mother." He washed out more of us than any other instructor. Flying ability seemed to have little to do with it. The cocky ones or the casual ones had the most trouble with him.

The training period was an eternity of torture. In no time, it had almost erased our lazy and carefree pasts from memory. The only direction we could see was ahead. Dangling on the horizon were a pair of Navy wings, which not only had become a symbol of nearly impossible attainment but were, like the flight pay, a perquisite in themselves. After all, who else but pilots could wear wings?

When we finally did make it, we had become so single minded about our ultimate position and function that all our other "selves" were nearly invisible. There was not the slightest doubt in our minds about what we were. We were Navy pilots, members of a tight and united community of Navy pilots, the most select, the most promising, the most needed, the most God-gifted of all men.

And who else is so jazzed up just after they get out of school?

Pilots Didn't Feel Close to Other Officers, Partly Because They Had Their Own Language and It Was Easier Just To Talk to Each Other

All through flight training, the build-up was, "when you get into a squadron" and "when the squadron gets to the fleet." There was almost nothing said about the ship itself and how we fitted in. So when we got our ship and landed aboard one day, we amazed and shocked the crew with our inclusive ignorance of ship routines and organization.

The ship was enormous, a maze of technology, a honeycomb of specialization. At first we couldn't even find our way around, not to mention understanding what all the paraphernalia was, what it was for, the voluminous edicts governing its use, who uses it, the protocol involved, and so on. Actually our initial curiosity was blunted by the incredible complexity of everything.

This feeling of strangeness, which lasted for many weeks, had the effect of drawing us even more closely together. We felt like a small minority and we were. There were literally thousands of enlisted men carrying out specialized and often incomprehensible assignments — mechanics and radiomen and ordinancemen, each group broken down into numerous specialties and subspecialties, the men who fixed and calibrated the radar, others who operated it, others who interpreted it. Besides the ship's radar, each plane type used a different type of radar, each with its own maintenance specialist.

There was no end to it. On the flight deck there were hook disengagers, wing folders, taxi signalers, radio checkers, instrument checkers, firemen, crashmen, corpsmen, signalmen.

The Navy had started years before sending these people to special schools. They were coming aboard ship with a specialty as well as a rating. On their sleeves they proudly wore the emblems of their attainment. Some of them even wore their own special kind of wings. When the Navy started doing this, the pilots made outraged protests. "Sure," we'd say, "we grant you that they deserve recognition, but this is confusing to the public. They'll think these guys are flying the damn airplanes."

Meet the "parapilots."

Their specialization notwithstanding, to us this array of highly trained technicians was still an amorphous mass we called "the crew." Even after months, there were few that we even recognized, not to speak of knowing them as individuals. They lived in a different world, status-wise and time-wise. We always said to ourselves that we should make an effort to know them, but there never seemed to be the time. There were pilots who went through a whole tour of duty without being able to identify some of the insignia they wore on their sleeves.

We knew the ship's officers better, since the Navy had made us equals in wardroom society. But that didn't mean we felt close to them. Partly it was because we had our own language. It was much easier just to talk to each other. Partly, but only partly, it was a matter of status, symbolized by the wings we wore on our shirts.

The latter point must be carefully qualified. The ship's captain, the exec and the air officer had wings, too, but that didn't mean they were in the brotherhood. They disqualified themselves on two counts: one, they were not actually flying with us (few command officers ever left the deck), and two, they were hopelessly and irrevocably organ-

ization men, at once the spokesmen and the servants of the ship. Among ourselves, we didn't consider them fliers at all.

Even squadron skippers were on trial until they established their loyalties one way or another. What we expected from them was steady and predictable leadership in the air, which implied a pretty fair competence as an aviator, and a readiness to go to bat for their pilots in any and all situations that involved a conflict with the ship.

Whether by brilliance or accident, the Navy did very well in its selection of squadron commanders. I never ran into a really bad one. They had an uncanny knack of picking men with absolutely no administrative abilities whatsoever and only the dimmest of ambitions for a postwar Navy career. This was exactly what the pilots wanted. The administrator-type was, by definition, not air-minded; the ambitious would inevitably cozy up to the high rank on board and try to sell us an organization bill of goods.

In short, there was a pretty clear line that cut across the officers' wardroom. There were the guys that flew the planes and there were the "gumshoes," our word for the guys that didn't fly the planes. I can recall our making only two exceptions to this social line of distinction. One was the landing signal officer. He had to be one of us because it was a psychological necessity that we trust him completely. The other was the flight surgeon. He earned his wings when he sold the captain on giving us the brandy.

Which should establish, if we have not already done so, that pilots and doctors are very close together in their basic thinking.

There Was an Unremitting, Obsessive and Ceaselessly Inventive Effort by the Organization To Get the Pilots on the Team

One thing the pilots all learned quickly was that spectacular success and complete disaster were always uncomfortably close companions. The first could rarely be realized without the near presence of the other. In fighters it was that extra 100 or 200 yards of pressing in close on an enemy plane. In dive bombers it was maybe about 1000 more feet of waiting to be sure before you pressed the release button. This, we assumed, was what our instructors had meant by "dedication" because this was the part that nobody could ever really make us do.

The fact that they couldn't make us do it put us under more of a strain, I think, than there might have been otherwise. Nobody was ever enthusiastic about being bracketed by a hail of small caliber fire near the ground or close to an enemy formation. Some days, though, we were less enthusiastic than others. Day by day, in other words, you fought a running battle with yourself about just how hard a try you would give it. Aside from the will power factor, there was a fine point of judgment. You had to know when success was impossible, when the real hard try was suicide, and a waste, when it would be wiser to come back and try another day. In spite of what the publicists said, these choices were often possible. Every pilot who lived through the war made them prudently.

This probably explains why the pilots, of all the groups on ship, were the least inclined toward open criticism of their fellows. The word of someone's conspicuous aerial failure stayed within the group. Usually we tried to make it easier for the man involved. All of us had failed on occasions, too.

If we ever heard another pilot's performance being criticized by a ship's officer or crew member, we rammed the words right back down their throats. It was very important to us that this kind of thing not be accepted, or even acknowledged.

At the heart of this ethic was a deep sense that no outsider could possibly appreciate what we were going through. Given this, we didn't grant any right of criticism.

So mixed in with our pride was a chronic inner discomfort. You had a responsibility. There was no limit to it. So you had to do the limiting yourself. What we did in the air war and the inner war that went with it completely wrapped us up. This was our nagging preoccupation, even when we weren't flying. This was what was important.

I try to explain this feeling because it in turn explains why the pilots drew such a clear line between themselves and the ship and why we were so suspicious of anyone whose primary interests lay with the ship's organization. They did not and they could not understand that our problems were always more important to us than any the ship could give us.

We wanted the ship to leave us alone with our problems. In return we were glad to let the captain and all his crew have theirs.

But it didn't work out that way. The ship had to involve itself in our problems because, as they put it, we were a part of the ship. For identical reasons, they argued that we should help the ship solve its problems, too.

As you can see, "togetherness" was a common theme in those days, too.

There was an unremitting, obsessive and ceaselessly inventive effort to get the pilots "on the team." It came at us like a crossfire from nearly every command department of the ship and from many levels of the Navy hierarchy from the task force right up to Washington. On the ship there was always someone from air plot, the flight deck, maintenance or air intelligence who sought and obtained an audience with the pilots to get their "cooperation and understanding" in the solution of some "mutual problem." We were beset by an endless stream of directives, reports, instructions and other paper from Washington. Nearly every

month the high brass changed its mind on how we should fly the airplane.

Not content with just educating us, the Navy had to study, test and evaluate us, too. In the later stages of the war, sociologists, psychologists and an assortment of other obscure functionaries in the human relations field began to close in on us. The word had gotten out and up, you see, that the pilots were "a problem" all through the fleet. One central thesis had apparently won full acceptance — that if someone could just figure out a way to build an identity of interest between pilot and ship, the war would quickly be won.

Our response to all of this wasn't exactly gratifying to the Navy. The pressure seemed to create its own resistance. Being preoccupied, we were easily bored with this kind of attention. Besides we quickly found that about half the ideas they had for us didn't work. You don't teach anybody to dogfight an F6F at 30,000 feet by writing a memo and holding a meeting, but these things were tried. We went to the meetings sure that none of the ideas was any good.

Sometimes it got so heavy that whole squadrons would work themselves into a kind of frenzy. "Why don't they leave us alone," we would ask each other, "and spend their time learning how to keep the damn canopies clean."

The canopies were a chronic and apparently insoluble problem. I once had four planes at a stretch that had an oil glaze on the windbreak front of the canopies. Obviously you couldn't sight very well on a target with oil distorting the image.

Getting the windshields cleaned properly was a problem. You'd ask the plane captain why he hadn't cleaned it, and he'd say he had. And you'd say that it wasn't clean, and he'd admit it wasn't. And then you'd tell him that the way to get oil off glass was to use a gasoline-soaked rag, and he knew that, too. And then he'd tell you his problem. There was an order against using gasoline-soaked rags on the flight deck with engines turning up. Then you'd ask why they hadn't cleaned it down in the hangar deck, and he didn't know. Besides it wasn't his responsibility. He was a plane captain, not a mechanic.

This upset me so much that I actually tried to find the man responsible for keeping that canopy clean. There wasn't a sailor on that ship, though, who would admit a responsibility for anything except in the physical presence of his chief petty officer. The chiefs, of course, were the unrivaled masters of self-absolution. Nothing was ever their fault. So you and your problem would land with some ship's officer, who didn't know the culprit either. It annoyed him to be asked because, as he put it, the chief handled all such details.

Besides those of us who were sore about dirty canopies, there were other pilots ranging furiously up and down the ship trying to find who had fouled up their guns or had forgotten to bolt down their engine housing or had reversed the wires on their elevator trim. If all of this accomplished nothing else, we did shake the chain of command from the bottom up and antagonized many an innocent member of the crew.

This got to such a point on one ship that the air officer called us together and told us in no uncertain terms to lay off his enlisted men. Then he announced with evident pride that he had a solution to the problem. From that time on, we were to channel our complaints through junior officers who had been assigned to each squadron just for that purpose.

Looking back over the years, the plight of these commissioned "trouble-shooters" inspires pity; at the time, though, we felt no charity and gave no mercy. From the very start, their jobs were a nightmare. They took the full brunt of every complaint that we had and some that we imagined. Often they didn't swing enough weight with the chiefs and the maintenance crews to get action. Often part of the message was lost in transmittal. Often it wasn't understood in the first place. Of course, they always got it worse from us the second time around when we discovered the thing never was fixed.

The failures of these three helpless ensigns confirmed the very darkest misgivings we had about administrative officers. They seemed to know everything but how to give us fast and dependable service. In the privacy of our ready rooms we delivered this unanimous verdict: They were "meddlers, bunglers, fools."

In how many doctors' lounges have these kind of cries resounded?

Bigness Blighted the Personal Touch and Made Communication Difficult; There Were Eternal Little Wars Being Fought

We soon had the feeling that nobody on the ship liked us. Walking along the catwalks on your way to the plane, you'd often hear profane mutterings from members of the crew — loud enough to get the sense of but never clear enough for positive identification. In their own ways the ship's officers made their feelings clear, too.

But though it was true that the ship wasn't very happy about us, it wasn't very happy about anything else, either. I was on four carriers during the war — one ship that was very good, two ships that were average, and one ship that was terrible. All of the ships were unhappy.

The reasons this was so are complex but familiar. Bigness had blighted the personal touch and thereby made communication difficult. People didn't feel like "shipmates" when they didn't see one another from one month to the next. There was some departmental esprit but it often had its outlet in vindictiveness against the men in other

departments. So there were eternal little wars being fought within the big war.

The Navy had passed out so many ranks and grades in so many specialties that there was a terrible status problem. They had a hard enough time even finding a place to put some of these people in the organizational structure. Making them feel that they fitted was a problem that few had time to tackle. The pilots weren't the only ones that had gotten specialized training and a build-up that made them feel the ship couldn't exist without them. It seemed like half the people aboard had had more or less the same experience. Everybody had their letdown, too.

So the pilots were not the only ones aboard that ship who were resented. In fact, we probably ranked a poor third behind the captain and the cooks. Resentments flowed up and down and across every line of the ship's organization, but they did tend to concentrate more on symbols than on personalities. The captain symbolized authority, the pilots symbolized special privilege, and the cooks symbolized food. On Navy ships, nobody ever liked any of these things.

In other words, the crew had to complain. It was a universal compulsion. In this respect the pilots were very much a part of the ship's organization, never lacking a contribution to the general chorus. For one thing, we were mad about the rule that permitted brandy only if you had been in actual combat with the enemy; our contention was that you needed it just as much after searches or combat air patrols when you could have been shot at and were fully expecting to be shot at almost any time.

Maybe 70 per cent of all the resentments and complaints were pointed in the general direction of the ship's captain. The foregoing complaint is a good example. Since we couldn't blame an unenlightened brandy policy on anyone else (the flight surgeon had tried hard), we had to blame it on the captain. Take all the specialized groups on that ship, multiply that by all the specialized interests they were trying to promote, and consider that most of these issues either would not and could not be resolved and would therefore be raised at least once a day every day at sea, and then you can understand why the captain spent so much time alone in his cabin.

The Navy Could Not Make Pilots Organization-Minded or Eliminate the Ambivalence So Often Noted in the Hospital Organization

There is much more that I could say about the aircraft carrier and its pilots. This should be enough, though, to cast serious doubts on the common assumption that the stresses and strains in the relationship of medical staff to the hospital organization, and vice versa, are absolutely unique, and that we can therefore get little help or solace from looking at the experience in other fields.

Having had a few years to mull all of this over, I can state with some assurance the following conclusions — about pilots and aircraft carriers, of course (but hoping, in the process, to stir up some good arguments about their application to hospitals and doctors).

1. **The conflict between pilot and carrier** would have persisted in any kind of organizational structure. Note that the Navy had denied the pilots any semblance of the functional authority that the physician has when he directs patient care activities within the hospital. There were no dotted lines for us. We had our place in the line of command, just like the others. But the Navy did not, by virtue of this decision, make us organization-minded or even eliminate the ambivalence and confusion that is so often noted in the hydra-headed hospital organization. Fifteen years away from my experience, I feel sure (without checking myself) that the Navy still hasn't solved this "problem."

2. **Strains in the pilot-carrier relationship** stemmed from a functional conflict, and not a conflict that derived from weakness in the ship's organization. The pilots were, and had to be, individualized and independent in their approach to their responsibilities; the carrier, by equivalent necessity, had to press constantly for conformity. A kind of uneasy equilibrium of these opposing forces had to be maintained. The process of maintaining this equilibrium went on outside the framework of shipboard authority and organization.

3. **The pilots had to be aggressive,** had to act like they had authority over the organization, in order to keep this balance. It comes back to the basic question of who else the ship was serving but us. We had to keep reminding them that it was us. Otherwise the organization would have swamped us. One day we lost a pilot off the catapult. He just dribbled off and under the bow of our ship going 30 knots full tilt into the wind. Some one at some time who had had something to do with that catapult had fouled up. Our squadron skipper was unforgettable that day. First he told off the ship's captain and then went straight down the line with everybody who had even a remote connection with that catapult. He never did find out who was responsible, but we didn't have any more catapult failures on that cruise, either. In bullying and antagonizing the ship's officers and crew, we were really protecting ourselves. We were acutely conscious of the fact that the ship, just like the pilot, was capable of disastrous error. Usually these errors hurt us.

4. **In spite of the pilots' sensitivity** about ship domination and direction, the last thing we really wanted was authority over the ship and the responsibilities attached thereto. Long before, the Navy had decided that this wouldn't work. Their reasons: (a) It took too long to train good pilots who were also skilled and knowledgeable about engines and electronics and the supervision

and organization of human activity. So they chose to concentrate on training good pilots. (b) The mission to be accomplished was so important that it was absolutely imperative that we be made a part of a much larger organization that keyed into large strategies and objectives. (c) They had to free us of any distraction that might interfere with the execution of our primary function. The pilots didn't argue with this. We felt we already had enough responsibilities. As stated, what we really wanted was good service.

What the Men in Command Were Really Asking Was Help in Solving Their Problems — and in This They Were Asking Too Much

Granting the organization its power and influence, then we had a right to expect decisiveness from the captains and admirals who held this power in custody. In other words, the last thing we really wanted was weakness and permissiveness from the men in top command. Since no decision of any importance was easy, these men had to have courage. To make up for some of my slanderous remarks, I would like to say that the Navy had a good quota of command officers equal to these decisions. If I had the time I could tell some good stories about them. Suffice it to say that long after most of the pilots' exploits have lost shape and significance, certain command decisions still live in my book as the most heroic acts of the whole war.

The pilots would never be, and could never be, members of a Navy shipboard "team" in any literal sense. This does not imply that cooperation with the ship was not important or necessary. It means only that the effort to get us to accept a shoulder-to-shoulder relationship with the ship was representative of a kind of loose thinking in administrative circles that is so often self-defeating.

The point is this: The only real "team" relationship the pilots had was with the other pilots. This had meaning. When the fighters, dive bombers, and torpedo planes did what we called a coordinated attack on an enemy ship, and actually coordinated it, that was teamwork. This was something quite different from our relationship with taxi-men, wing folders, or mechanics. They had to accommodate themselves to us, like the trainer on a football team. Certainly it was important to work smoothly with them, but when they asked us to understand their problems and make their jobs easier — in the analogy, run interference for them — they were asking too much.

We were rightfully suspicious of this kind of "team" talk. It is significant that it was most prevalent on the worst ships. What the men in command really were asking was for help in solving *their* problem. They had to make a complex and sometimes unwieldy organization work; it was all too easy to blame its failures on the group upon which all activities focused.

Those who spent more time coordinating and perfecting these supportive activities had many less problems with the pilots. This is where administrative genius could have been used to good effect but usually wasn't.

It was a good thing the admirals and the captains never occupied themselves very seriously with the problems of human relations, of making their subordinates happy with their jobs and happy with each other. If they had gotten into this problem, we'd still be trying to win the war.

New England Hospital Assembly Names Dr. Isadore S. Geetter President-Elect

BOSTON. — There is a simple solution to the puzzle of the disappearing third-day audience at three-day meetings, and the program planners of the New England Hospital Assembly found it. At the 26th annual assembly here March 23-25, they just scheduled the hottest subject for the afternoon of the last day — and there was the audience, filling all the chairs of the largest meeting room, and anxious to hear about the progress of Progressive Patient Care.

As it turned out, the delegates attending this session received an extra, unscheduled, dividend. Before the panelists embarked on their discussion, Dr. Elliott Joslin, renowned specialist in diabetes and founder of the Diabetes Foundation Clinic of New England Deaconess Hospital, proudly reported that the hospital had lowered its charges to the diabetic patients by a dollar a day. Dr. Joslin pointed out that this has been achieved because the patients, who come in for diagnosis and to learn how to control the disease, are ambulatory and able not only to care for their own needs and look after one another to a large extent, but also do a bit of "light housekeeping," such as making beds and carrying trays.

Teaching Costs Less

He had requested permission to present his brief report at the session on progressive patient care because he considers the diabetes clinic a special form of progressive care. In conclusion, Dr. Joslin asked why it wouldn't be a good idea for all hospitals to have teaching clinics for patients in various categories who need teaching rather than nursing. Such clinics are considerably less expensive for both patients and hospital than bed care, as the experience at New England Deaconess has demonstrated, he said.

At the business session, Dr. Isadore S. Geetter, director of Mount Sinai Hospital, Hartford, Conn., was named president-elect of the assembly. Dr. Philip D. Bonnet, administrator of Massachusetts Memorial Hospitals, Boston, took office as president, succeeding Francis C. Houghton, Rutland Hospital, Rutland, Vt. Registration at the assembly totaled 5231.

The panel on progressive patient care comprised Dr. Howard Lockward, of the medical staff, and Edward J. Thoms, administrator, of Manchester Memorial Hospital, Manchester, Conn., who came to explain what progressive patient care is, how it benefits patients and staff, and how it has developed and expanded at Manchester since its inauguration in 1957, and Eleanor Lambertsen, R.N., assistant secretary of the A.H.A. council on professional practice, and Dr. Ernest C. Shortliffe, associate executive director of Hartford Hospital, Hartford, Conn., who came to ask questions as to the problems that were likely to be encountered, whether progressive care raised or lowered costs, how patients and staff react to it —and, in general, to stir up a discussion.

Neither Dr. Lockward nor Mr. Thoms contended that progressive patient care is the answer to all problems of patient care or costs, and they freely acknowledged that an immense amount of thought, planning and salesmanship were required to make the Manchester program work. They did point out that the plan has proved workable at Manchester and has been enthusiastically accepted by both patients and staff. The original plan of setting up three units, *i. e.* intensive care for acutely ill patients, intermediate care for those who are not so ill, and self-service for ambulatory cases, has been expanded to include a seven-bed unit for continuation care for the chronically ill, and home care service, which is rendered in cooperation with the Manchester Public Health Nurses Association. These five units, the speakers explained, represent broad areas of patient care. In practice, they shade into one another and form a continuum of care based on medical need.

New England Officers. Seated, left to right: President Philip D. Bonnet, M.D., and treasurer, Pearl R. Fisher; standing: President-Elect Isadore S. Geetter (left) and Wesley D. Sprague (right), secretary of the assembly.

That progressive care is not the only problem to which the delegates were seeking answers was indicated by the large attendance at sessions on control of infections, financing nursing education, hospital costs and utilization, medical staff education, better patient care, and trustee responsibilities.

As is usually the case at New England assemblies, the trustees turned out in force to learn from other trustees and from administrators and such specialists as Dr. James P. Dixon, commissioner of the Philadelphia Department of Public Health, and Dr. Kenneth B. Babcock, director of the Joint Commission on the Accreditation of Hospitals, how they can do a better job.

The Patient of the Future

At the morning session, Dr. Dixon sketched a picture of the hospital patient of the future to give the trustees an idea of what hospitals of the future will have to be in order to meet the needs. Summarizing the general characteristics of the patient of the future, Dr. Dixon said:

"He will be more numerous, he will cluster in his own home around a metropolitan area, he will be older, he will be earning more money, he will be in more skilled occupations than at present, he will be physically larger, he will be mobile, and he will be living in continuously more homogeneous culture."

As to the diseases that will afflict this patient, Dr. Dixon pointed out that "unless new bacteriological or viral invaders make their appearance on the scene, our communicable diseases will soon be reduced to those of a relatively minor disabling character.

"At the same time, chronic diseases are assuming an increasingly dominant role in the health scene. Thus, at the turn of the century, chronic diseases accounted for 46 per cent of all deaths and acute diseases for 41 per cent. In 1955 chronic diseases accounted for 81 per cent of all deaths

(*Continued on Page* 156)

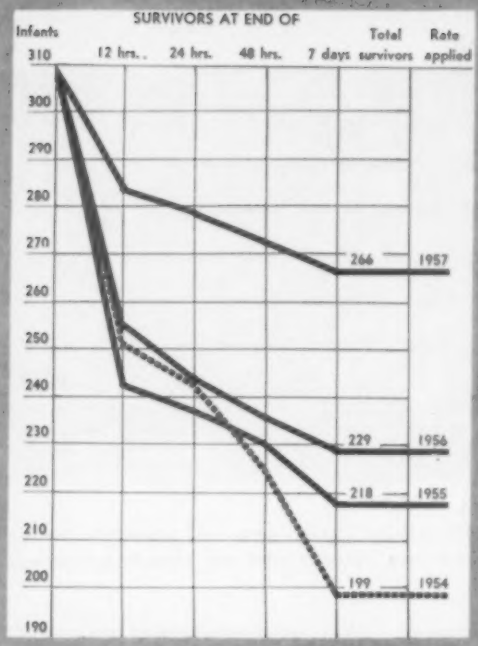


Fig. 1. Shows number of survivors if mortality rates of previous years had prevailed for 1957.

The program of premature infant care described here reduced the mortality rate 50 per cent in a three-year period

Arthur W. Fleming, M.D., and Isabelle Cody, R.N.

Premature care plan saved 60 lives

GOOD care of premature infants depends chiefly on coordination of the efforts of obstetrician, pediatrician and nurse, as well as those of the general practitioner, anesthesiologist and pathologist and the social service worker and dietitian. An interested hospital administration with the backing of the public health services, the parents and local organizations can then provide a community with good premature care.

Adequate medical supervision must be available, with hospital administration ready to back up the special regulations necessary. There must be teamwork and understanding of the highest order between physician and nurse. The nurse must have sufficient authority and be capable of exercising it.

Among the problems are (1) the necessity of establishing a means of obtaining adequate help and (2) devising a plan for stimulating interest in younger nurses so that future replacements will be available. These problems must be well understood by the director of nurses as well as by the administration. The latter must be adequately informed concerning the special problems of premature care, and how success or failure in the premature nursery can affect the hospital as a whole. The furnishing of an adequate physical plan along with all necessary equipment is also the duty of administration. Availability of proper counseling for the parents can help assure the infant of a good start in life.

Necessary changes were brought about at Little Company of Mary Hospital, Evergreen Park, Ill., by special training, conferences, new regulations, and a new physical plant.

The Sister in charge of the nursery took special training in premature care and induced some of the nurses to do likewise. Pediatric supervision was given by the late Dr. Edmund G. Lawler.

During these early days a set of regulations was worked out based on the recommendations of the American Academy of Pediatrics committee on

Dr. A. W. Fleming

Arthur W. Fleming, M.D., is chairman of the Little Company of Mary Hospital pediatric department. He had been secretary of the pediatrics staff and director of the premature nursery since 1954. Dr. Fleming is a graduate of Rush Medical College of the University of Chicago. Since 1937 he has been teaching pediatrics at Stritch School of Medicine, Loyola University. Isabelle Cody, R.N., is head nurse of the premature nursery at the hospital. She received her training at St. John's Hospital, Fargo, N.D. In 1933 she joined the Little Company of Mary staff specializing in nursing. In 1955 she attended a special course in premature care.

Isabelle Cody

fetus and newborn. Conferences for obstetricians, general practitioners, and pediatricians were held under pediatric leadership. Finally the regulations were adopted by the departments of obstetrics and pediatrics and then by the general staff.

Simultaneously, the administrator arranged meetings with representatives of the state and county public health services.

As a result of these meetings and conferences a plan of premature care was developed for Little Company of Mary Hospital. This involved: (1) a change in the physical layout of the obstetrics and pediatrics departments. This included the establishment of three regular nurseries on the seventh and eighth (the obstetrics) floors and a separate isolated premature nursery on the ninth (pediatric) floor. (2) The application of new regulations for all nurseries with special regulations for the premature nursery with full administrative backing. (3) The establishment of adequate and interested medical supervision of both the general and premature nurseries. (4) Proper equipment for the premature nursery with isolation incubators, suction equipment, air conditioning, and oxygen outlets.

The first stage of implementing the plan involved transfer of premature infant care to a separate room adjacent to the regular nursery. Here the infants were under the care of a nurse specially trained in premature infant nursing. Medical direction was given by Dr. Lawler.

The next stage concerned the application of the new regulations to premature care in the hospital. With this, a pediatrician with special interest and training in premature care was appointed physician-in-charge of the premature nursery.

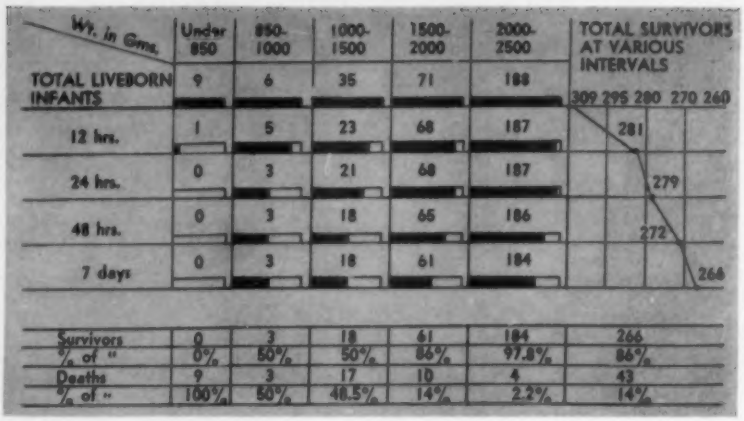


Fig. 2. Chart taken from 1957 statistics shows number of premature babies surviving at the end of various time intervals and per cent that survived.

During the period, the nursery was staffed with people who either had adequate training or had the capabilities of being trained in the department. They, as well as the medical staff, attended special educational events as well as many conferences.

Things were then ready for the move into the new premature department which was accomplished in July 1955. During the next few months, various adjustments were made among the nursing personnel and the medical staff.

Some personality differences among the nursing personnel were brought to the surface. Some nurses did not fully realize the seclusion of work in the premature nursery nor its complications, and were unable to get sufficient satisfaction out of their work. For most nurses, great personal satisfaction is possible. Changes and adjustments were necessary and these were gradually worked out.

During development of the plan, the majority of the medical staff cooperated well. A few members were somewhat reluctant to accept the change. As time has demonstrated the improvement in infant care, these men have gradually accepted it. A proper training program for interns and residents was another aspect of the medical side of the program.

During this period the wholehearted backing given by the administration was most important. In fact, it is doubtful if the successful end result could have been achieved without it.

Attention was given to the study of special problems of care of prematures. Information was shared with the medical and nursing community by means of talks and medical exhibits.

Our plan provides for adequate medical and nursing care, minimum handling, restriction of contacts, and properly informed parents.

The nursing care of the premature infant consists of using a strict aseptic technic and close observation by a well trained nursing staff which realizes the importance to the infant of excellent technics.

All babies are received by the supervising nurse and placed in heated incubators (90° F.), full humidity with oxygen (30-40 per cent) on admission to the nursery. Oxygen concentration is checked every four hours with an

Premature nursery at Little Company of Mary Hospital. In background are special incubators that permit nurses and doctors to attend the baby through portholes in the sides.

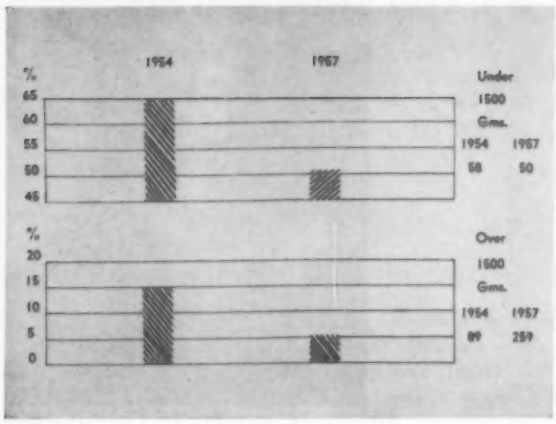


Fig. 3. Comparison of premature mortality rates for groups over and under 1500 grams for 1954 and 1957.

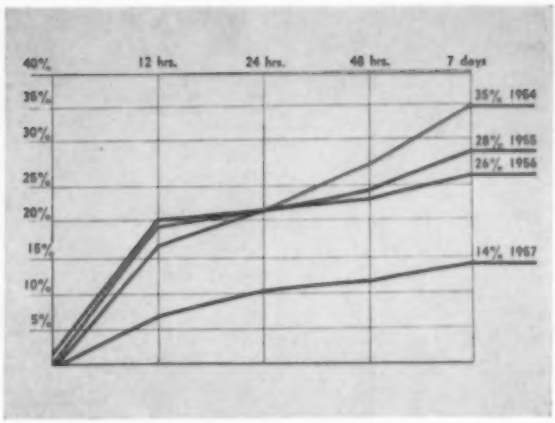


Fig. 4. Shows comparison of the premature mortality rates at the hospitals for years from 1954 to 1957.

analyzer and recorded. Infants in oxygen longer than 72 hours are removed gradually. A special mark on the incubator and chart designates an infant receiving oxygen.

A stomach lavage with normal saline is performed on each baby on admission to remove excess mucous from the stomach, and thus lessen chances of aspiration and hyalin membrane disease.

Temperatures are taken every eight hours and, except for the admitting rectal temperature, are taken in the exilla.

Time of starting the initial feeding depends entirely on the baby's condition and is usually between 24 and 72 hours after birth. Gavage feeding is used on all infants under 1500 gm. as well as on those having difficult respirations or a poor sucking reflex. The change from gavage to nipple is done when the infant is strong enough and is done very gradually. First, a very soft latex nipple is used, then a firmer nipple in preparation for discharge. Parents are advised to use well boiled nipples.

Bags containing one pound of rice are used in an effort to help shape the baby's head, which often becomes elongated early in life. These are placed on either side of the baby's head. This is started when the baby's condition warrants it and is used before feedings. It is usually continued during the hospital stay of the infant and may be continued longer after instructions are given to the mother.

It has been found practical as well as beneficial to care for sick infants in isolation incubators without removing them from the premature nursery.

The relationship of the nurse to the parent is extremely important. It starts with the initial visit by the nurse to the mother after her baby has been admitted to the nursery. This usually follows the meeting of the mother with the obstetrician and pediatrician.

The nurse attempts to get to know the mother and gain her trust. This is necessary but sometimes difficult, since a woman may be jealous of a nurse who cares for her baby at a time when she cannot have it. The nurse emphasizes the fact that she cares for all the babies and attempts to give the mother the security and knowledge that she cannot replace mother love. This trust is fostered during the baby's stay in the hospital and later in telephone conversations and at visiting time. Considerable information is also obtained about family and home conditions. Interest in the parent and in details of the baby's progress help to establish it as a family member.

The baby's hospital stay is climaxed by a demonstration of bathing, feeding and general handling of a premature baby for the mother before she takes the baby home. If necessary, other visits are arranged to establish the mother's security. Reaction to the demonstration may help to estimate the best dismissal time for the baby.

From the medical standpoint, all infants under 5 pounds are transferred to the premature nursery and must be under the care of a qualified pediatrician during their hospital stay. He cares for the infant within certain restrictions that have been accepted by the medical staff. The pediatric resident must see and evaluate each infant within an hour of the time it arrives in the nursery. He then writes preliminary orders and informs the pediatrician who is to care for the infant of these orders and of the condition of the baby. This pediatrician then assumes responsibility for the infant and is expected to see him within the first eight hours of life.

Discharge depends on: (1) the infant's reaching a weight of at least 5 pounds; (2) home conditions being adjudged satisfactory; (3) the mother's being sufficiently instructed to care for the infant. As previously stated, the nursery is in charge of a specially qualified pediatrician with special interest and training in the care of the premature infants and with sufficient authority and administration backing to enforce nursery regulations. In actual practice the use of this authority is now seldom necessary as our method of premature care is well accepted.

The accompanying graphs illustrate what occurred in the nursery during the four years 1954 through 1957.

The program of premature care as outlined has resulted in sufficient interest and cooperation to reduce the mortality rate by 50 per cent in the last three years as illustrated by the graphs. In other words, 60 infants lived in 1957 who would have died had the previous mortality rate prevailed. ■

Ambulance driver delivers suitcase-size incubator with premature infant. The two small tanks supply oxygen.

Prematures gain in radiant-heated

As ambulance arrives at Babies Hospital, public health nurse checks transporting of her charge.

Still in the special portable incubator, the baby is transferred to the special premature nursery at hospital.

Deftly the nurses prepare to transfer premature infant to incubator with specially controlled atmosphere.

incubators

IN THE suitcase-size incubator carried by the messenger shown in the pictures at left is a 1 pound 11 ounce infant on his way to the premature nursery of Babies Hospital, New York, where a radiant-heated incubator will keep his temperature on an even keel from minute to minute.

One of the latest devices designed to overcome a serious hazard to premature infants, this incubator is the special pride of Dr. William A. Silverman, director of the premature nursery. It provides a microclimate that is believed to come considerably closer to the ideal environment supplied by the mother's body than has heretofore been achieved.

Must Maintain Warmth

"Just keeping prematures warm enough, but not too warm, has been the toughest part of the job," Dr. Silverman explains. "Few of these babies can live unless body temperature is maintained on an even keel and not one has the resources for temperature regulation. . . .Until recently we have not been able to provide minute-to-minute individual control of the temperature of the incubator to respond to the changing heat requirements of each infant. Now we think we have the thing licked."

In the radiant-heated incubators, the air is supplied at a controlled base temperature of 86° F., but this heat

Finally, infant is placed in incubator with supply of air tailored to his needs. Doctor checks through plastic "sleeves" in side.

supply is supplemented by special lamps. How the incubators work is described by Dr. Silverman as follows:

"The lamps, placed at the top of the incubator, provide radiant heat from the infrared band of the spectrum. In this way, the baby absorbs heat directly from the heat source, instead of taking it from a moving blanket of warm air. Another advantage is that the 'on-off' response to radiant heat is almost instantaneous.

"Each infant wears a temperature-sensing element attached to his abdomen. Through feed-back controls, this small wire activates an automatic shut-off of the infrared lamps the instant the baby's body temperature goes above a set level. Thus the device also provides automatic adjustment to varying levels of air humidity which affect the body's ability to lose or gain heat.

Guarded by "Artificial Baby"

"In each incubator there is an 'artificial baby' — an assembly of glass tubing enclosing a heat-sensitive element — which safeguards us against any flaw in the operation of this automatic temperature control system. If the temperature of the 'artificial baby' should go above the safety point, a red light and an alarm buzzer alert us to trouble."

Work on the automatic system of heat control has been done by Dr. Frederic J. Agate of the department of anatomy in cooperation with the manufacturers who supply the incubators, Dr. Silverman explained. This work has been aided by a grant from the Dunlevy Milbank Foundation.

The incubators, according to Dr. Silverman, have made it possible for the first time to keep premature infants at the normal body temperature of 98.6° F. It had not been possible to warm them up this much before, he explained, because they shot above this temperature point too quickly, at the risk of damage before the change could be detected.

Whether 98.6° F. is the best temperature for the prematures is a question as yet unsettled but Dr. Silverman and his associates expect to have an answer in a few months. It will come Dr. Silverman believes, as a result of the sort of objective, controlled studies in the premature nursery that have helped to open not only life but normal health to the premature infant. ■

Good Training of Nurses Is Up to Doctors

On the principle that doctors are partly to blame when nursing care is not all it should be, the medical staff of this hospital is working with the nursing faculty to help prepare students for their professional role, and its efforts are paying off in better interpersonal relations and improved nursing service

M. Norman Orgel, M.D., and David Littauer, M.D.

IN THE opinion of all too many physicians, nursing care of their patients is adequate but not what they wish it to be. This view is shared by patients. Why are they dissatisified? Is it solely the fault of the nurse? Or are physicians also partly to blame? If the patient tells the physician he is unhappy with the care he is getting, it might be expected that the doctor will react unfavorably. If orders are not carried out, if the patient does not get the correct medication, or if a planned laboratory procedure is not done, the doctor can justifiably claim that the nursing service is deficient.

We must recognize that the opportunities for error in an area of complex personal service like nursing are enormous. At the Jewish Hospital of St. Louis, on a typical week day, we kept track of the numbers and types of one segment of nursing activities – the so-called "routine" procedures that nurses perform at the bedside. On that day there were 405 patients on the medical, surgical, obstetric and pediatrics services (chronic medical, rehabilitation and psychiatric services were excluded). On that day members of the nursing department completed the following procedures:

Oral medications	2131
Hypodermic injections	268
Intramuscular injections	280
Parenteral fluids	64
Catheterizations	14
Enemas	52
Treatments (bladder irrigations, wet packs, Sitz baths, dressings)	576
Blood pressures	466
	3851

This average of almost 10 procedures per patient, carried out for and with patients whose conditions varied from convalescent to moribund, does not include such activities as charting, taking temperatures, watching oxygen equipment, and the other demands on the nurse. The percentage of errors or deficiencies in relation to the total numbers of orders is low, and most of them are minor and can easily be covered or corrected by the doctor in charge. Surely the occasional mistake cannot by itself be the reason for the physician's dissatisfaction with nursing care, unless he chooses to make it so.

Whether he chooses to magnify the occasional error, even though it may be minute, and whether he transmits knowledge of the error to the patient, depend on his attitude toward the nurse who was responsible. This attitude in turn is conditioned in part by his impression of the status accorded to him by nurses in general.

In assaying the factors that influence how physicians feel toward nurses, and how nurses react toward physicians, a good starting point is the school of nursing. The student enters school with enthusiasm and devotion, visualizing herself as a ministering angel ready to soothe a fevered brow, a woman in white helping the noble physician to nurse the desperately sick person back to health. This is the Florence Nightingale approach – this is the picture we sold her. It can be seen any time in promotional ads or on television. Remember, she is 17 or 18 years old and has just been graduated from high school. We consider the 17

M. N. Orgel, M.D.

Dr. M. Norman Orgel is an internist on the staff of the Jewish Hospital, St. Louis, and chairman of the advisory committee to nursing service of the hospital. He is a graduate of the College of the City of New York, Harvard University, and Washington University Medical School. Dr. David Littauer, executive director of the hospital, is a lecturer in hospital administration at Washington University and St. Louis University, chairman of the committee on care of the chronically ill and aged of the A.H.A., and a former president of the Missouri Hospital Association. He is a fellow of the American College of Hospital Administrators.

David Littauer, M.D.

year olds in our own families and those of our friends pretty young and immature, and it is hard for us to realize that these nursing students, of whom we expect so much, are the same age.

Much of this enthusiasm is lost when she is assigned to a nursing unit, and is directed and molded by her instructors, by graduate staff nurses, by older (though not much older!) students, by full-time and voluntary attending physicians, and by the young doctors who comprise the intern and resident staff. She finds that she resembles a foreman more nearly than a comforter and healer. Practical nurses and aides now perform most patient comfort tasks. The duties of a student nurse now are principally administrative, revolving about the nursing station, or impersonal professional work, like preparing medication. But we never told the student that she would have to be an administrator and a technician when we recruited her, nor did her early indoctrination in the school prepare her for such responsibilities.

Some student nurses, disillusioned, drop out. Others continue to graduation, with their minds made up to enter industrial, office, public health, or private duty nursing. And all too many graduate nurses who have survived the stern realities and are doing hospital nursing require only the additional rationalization of marriage or inconvenient hours of work or lack of parking facilities to leave the field entirely or to switch to one of the other types of nursing. Since the average age at marriage for women has dropped from 22 to 20 in recent years, many senior students are likely candidates for marriage and departure from the field just about the time they receive their diplomas.

If the young married graduate does stay in active nursing, there are competing demands upon her interests and time. She is reluctant to assume the responsibility of the head nurse and the supervisor, vital links in the chain of command of nursing service, or to continue studies that would fit her for such a role.

And what sort of understanding does the nurse who makes a long-term career of her chosen profession receive from physicians? All too often, we hear physicians remark, "Years ago Miss So and So ran her floor with an iron hand and the nurses did everything just so." Or, "Years ago the nurses stood up when a doctor came to the desk. Maybe it would be best to start this again." Such memories of the past are often rose tinted with the passage of time. Senior physicians have no difficulty in visualizing the contrast in duties and actions of present-day interns with the situation when *they* were interns! Nursing service has changed as much as the procedures of medicine.

Physicians must bear their share of responsibility, too, for the increasing demands they make on the nurse in caring for their patients. Not only has the turnover of patients per bed increased, but also the medications used have multiplied rapidly and the number and intricacy of technical procedures have increased. The day when only a doctor could give an intramuscular injection or start an intravenous infusion is not far behind us; even taking a blood specimen was the province only of the physician. Now we use transfusions, electrolytes and various methods of oxygen administration, and to this oxygen we add many other inhalant medications. We are moving rapidly, in fact, into areas of specialized procedure and equipment on the "nursing" floors that are beyond the capabilities of a nurse with ordinary training to handle.

Our problem of physician-nurse relations is complicated by the dissatisfaction that today's patient has with the type of nursing care he receives. His image of a gentle ministering angel during his period of helplessness and pain quickly blurs. It has become apparent, from sociological and psychological studies, from reputable and documented articles in newspapers and magazines, and from personal exposures to patients and their families, that the patient is bewildered by a succession of functionaries who enter his room. Each individual comes to per-

You Ought To Watch Your Manners, Doctor

How do we foster a good relationship between nurse and doctor? The nurse is being squeezed by many forces. Her personal contact with the patient is being taken away by nonprofessionals; the technician is replacing her in many areas; she is faced with a multitude of administrative and secretarial duties that she does not feel is her true role. The doctor is her potential ally if he will but understand her problems.

If three doctors come on the floor at one time, she cannot give undivided attention to each one at the same time. She can accompany only one while he makes rounds, and sometimes the only way she can avoid difficulties is by going with none.

The nurse is interested in the manifestation of disease. How many of us routinely show the nurse, student or graduate, the tumor we so carefully feel or let her listen to the murmurs we talk of so interestingly?

It is easy for us to forget the level of education a student nurse has reached. The orders or the demonstrations given to a third-year student would not be suitable for a first-year student. This is a common complaint.

Do we treat the nurse with the dignity befitting her professional training? Have we said things in anger that should be left unsaid or have we, on the other hand, indulged in familiarity that should be deferred?

Many of us have been guilty of using the nurses' station as a forum from which to discuss our opinions and to condemn the activities of groups and individuals within and outside the hospital. Many of us have not hesitated to comment on the professional abilities of house officers or even our practicing colleagues. Some of us have even questioned nurses about their feelings toward their superiors. In doing so we lower ourselves or our colleagues in a nurse's eyes. We must exercise reasonable restraint if we expect to maintain her respect.

form a specific and discrete task: One takes his temperature; another gives him a bath; yet another clears the overbed or bedside table for the meal; while still another "passes" medications. And the same task may be done by different individuals in the course of 24 hours. The patient feels as if he is in a revolving door. He can find no one to whom he can cling as "my nurse." It is hard for him to get a sense of belonging when we substitute the whole nursing service for "my nurse."

The professional nurse is caught in the same revolving door. Her contacts with each patient are so temporary and compartmentalized that the patient is a room number and a disease; the individual does not shine through.

Here at the Jewish Hospital the medical staff advisory committee to the nursing service has addressed itself to the problem of keeping nurses in the hospital to care for patients. It has become convinced that an important part of the solution rests with physicians themselves: If they show understanding of the nurse's role, they will be able to foster a feeling of warmth in the nurse in her relationships with patients as well as doctors.

The committee has tried several approaches. Some concern changes in attitudes; some deal with improvements in the pattern of immediate care of the patient.

Members of the medical staff committee have met with the faculty of the school of nursing to work out methods of helping the student to understand and be prepared for her new role, to develop understanding of the patient's needs, and to meet these needs with warmth. In these efforts the committee has the help of professional sociologists and psychologists.

The school of nursing is now grading students not only on their abilities but also on their sympathy and warmth and "outgoingness" to both patients and physicians. The student understands that this is a vital part of her training.

At the suggestion of the committee, a questionnaire was sent to all nurses who were graduated from this hospital's school of nursing or who have recently worked in this hospital, asking the nurse to tell us why she left here, if she did, or why she continues to work here, and how this hospital compares with other hospitals in the nurse-hospital relationship. The answers have pointed out our strong points and our shortcomings.

The nursing service, with the advice of the advisory medical staff committee, has experimented with several variations of the traditional pattern of floor duty nursing care, prompted by the observation that on a general duty nursing floor, nurses tend to gravitate to the bedside of the one or two critically ill patients (even though the care the rest of the patients receive is reduced somewhat) for here the nurse can assume the role to which she aspired on entering training.

For students, the nursing service offers experience in "total nursing care" for selected seniors and juniors. In this program one nurse takes care of all the needs of four to six patients, including bathing, bedmaking, passing medications, and bringing in the mealtime tray. Patients and student nurses are pleased. The physician is aware of the student as an individual nurse, not as an impersonal, rarely seen technician.

We have also experimented with group nursing, whereby three patients are cared for by a graduate professional nurse on each shift. An extra charge is made which is about 50 per cent of the private duty rate. Group nursing has worked well for many acute medical and some major surgical conditions, and reactions from patients and physicians who have used it have been overwhelmingly favorable. It is not the complete answer, however, for the patient who is so sick that he must be watched continuously, must have complete resuscitative and transfusion equipment immediately at hand, and cannot be left behind the closed door of his room. Moreover, it is a luxury service, beyond the reach of many patients. Nevertheless, group nursing, by bringing the nurse back to the bedside, has, in our opinion, contributed to the improvement of patient-nurse and nurse-physician relationships.

Along with a number of other hospitals, we have been studying the feasibility of "progressive patient care" and "intensive nursing care." For reasons that are beyond the scope of this report to detail, we do not believe that "progressive patient care" as has been described in the literature is easily adaptable to the voluntary hospital in a metropolitan setting, since it creates as many new problems as it solves old ones. We are thinking rather of expanding the type of intensive care already being given in the postanesthesia recovery room.

We believe that these efforts to prepare student nurses for their professional role, to remind the physician of the respect and understanding he owes the nurse, and to bring nurses back to immediate care of patients are paying off in improved interpersonal relationships among nurses and patients and nurses and physicians. ■

Questions and Answers on Group Nursing Service

Can any patient be admitted to the service?

All except pediatrics, maternity, psychiatric or contagious.

How is this service staffed?

Experienced nurses, regular employes of the hospital and responsible to the nursing department, constitute the "share the nurse" staff.

What are the costs of this new nursing service?

For this individualized service, the patient pays the hospital at the rate of $22 for 24 hour care.

How much do I save?

Full-time private duty nursing costs $48 for 24 hours of coverage. Group nursing saves you $26 for each 24 hours of care.

How am I admitted to a Group Nursing unit?

All reservations will be made by your physician.

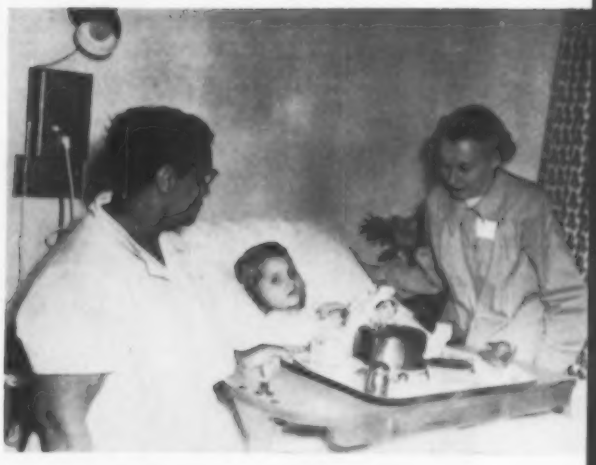
How long do I stay in this unit?

As long as your physician believes your condition warrants it.

Above: Board members of Montclair Community Hospital report to the hospital administrator (seated at end of table) for assignment.
Left: Board member, left, works at reception desk in the lobby.

Right: Board member assigned to pediatrics department introduces himself to small patient out for a stroll with his mother in the corridor.

Trustees Work To Learn How the Hospital Works



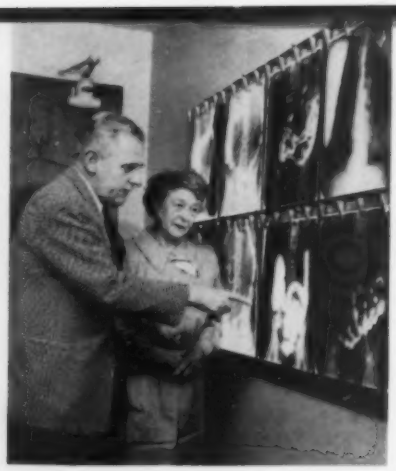
MEMBERS of the board of managers of Montclair Community Hospital, Montclair, N.J., learned what hospital employes do all day long by doing it themselves – and they loved every minute of it. Their lesson in how the other half works was an experiment devised by the hospital's director to help the trustees gain a better understanding of the hospital for which they are responsible.

As Katharine F. Skogsberg, the director, explained: "For about 10 years we have had an orientation session for new board members, which included a tour of the hospital and meeting the employes at work, but we have found it difficult to let the members, particularly the men, see the hospital as it operates in the middle of a busy weekday. For that reason we chose Lincoln's birthday, a holiday for them but not for the hospital."

Promptly at 9 o'clock on February 12, Mrs. Skogsberg reported, 19 of the 30 board members (both men and

Top: Encouraging a little girl to eat her lunch is part of the day's work for the trustee working in the dietary department. Center: Woman board member holds patient's doll and tries to lure child into conversation. Left: A patient explains to coordinator of volunteers how to work a puzzle.

Right: A member of the hospital's medical staff interprets x-ray films for the trustees. Below: Board member (right) watches treatment in outpatient department; and a board member (right) visits laboratory.



TRUSTEES HAVE ADDED

women) presented themselves for their work assignments. They were given a brief program for the day, a list of the key employes of the hospital, name tags, and work clothes when uniforms were required. Each board member met his counterpart on the job and spent the next six hours with him. Lunch was served in the employes' dining room and each trustee had lunch with an employe in the department in which he was working.

At 3 p.m. all 19 board members gathered in the conference room with the director and assistant director of the hospital. Each completed his as-

Below, left: Trustee watches central supply supervisor place flasks in the sterilizer. Below, right: Two board members see how linens are handled.

Left: Bookkeeper explains machine accounting to two members of the board. Below: While the record librarian reads the microfilm, a board member chats with doctor; and a trustee studies fire safety.

CONFIDENCE IN STAFF

signment by filling out a brief evaluation report. This was followed by a 30 minute discussion which was so lively, Mrs. Skogsberg said, "that it was hard to give everyone a turn to talk."

There was unanimous agreement that the day had been worth while. One trustee who had spent more than four hours in the operating room witnessing surgery said: "I feel this experience has increased my confidence in the staff and facilities of the hospital and I think this idea should be pursued more frequently so our board can become more familiar with the functions here." ■

Below, left: Board members go into a huddle about a boiler problem. Below, right: At the end of the day trustees evaluated their experiences.

ABOUT PEOPLE

Administrators


Dr. Rosenkrantz

Dr. Jacob Alvin Rosenkrantz has been appointed director of Beth Israel Hospital, Newark, N.J., effective August 1. He will succeed **I. Ellis Behrman,** whose retirement was announced in The MODERN HOSPITAL last month. Dr. Rosenkrantz is currently administrator of Albert Einstein Medical Center, Southern Division, in Philadelphia. He is a graduate of the College of Physicians and Surgeons, Columbia University, is a fellow of the American College of Physicians, and a member of the American College of Hospital Administrators. Before becoming affiliated with the Albert Einstein Medical Center in 1956, Dr. Rosenkrantz was director of professional services at the Veterans Administration Hospital, East Orange, N.J., for more than four years, and prior to that he served as assistant director of professional services at the V.A. hospital, Bronx, N.Y., and held various key posts in the U.S. Army Medical Corps during World War II.

Daniel W. Hartman has retired as administrator of Williamsport Hospital, Williamsport, Pa. He will continue as executive director of the development program and consultant to the board. Prior to his appointment as administrator, Mr. Hartman was superintendent of the Lycoming County Institution District. He is a fellow of the American College of Hospital Administrators. **Paul G. Wedel,** assistant administrator for the last five years, has been named to succeed Mr. Hartman. He is a graduate of the program in hospital administration at Northwestern University. Mr. Wedel is a member of the American College of Hospital Administrators. He will be succeeded by **Robert L. Engel,** formerly administrative assistant at Cincinnati General Hospital, Cincinnati. He has a master's degree from the Graduate School of Public Health, University of Pittsburgh.

J. Russell Shawver has been appointed to the newly created post of assistant hospital administrator of White Memorial Hospital, the Los Angeles teaching hospital of the College of Medical Evangelists. Formerly patients' business manager at Glendale Sanitarium and Hospital, Glendale, Calif., Mr. Shawver will receive a master's degree from the University of Chicago in June.

Frederick R. Wolf has been appointed administrative services director, Philadelphia General Hospital, Philadelphia. He was formerly administrator of Children's Hospital, Fort Worth, Tex.

Dr. Benjamin G. Dinin has been appointed director of Grasslands Hospital, Valhalla, N.Y., succeeding **Dr. Edwin L. Harmon,** who has retired. Dr. Dinin was general medical superintendent of the New York City department of hospitals.


R. E. Heerman

Ritz E. Heerman, executive vice president of the Lutheran Hospital Society of Southern California, died April 23 at the age of 67 following a brief illness. Mr. Heerman, a past president of the American Hospital Association and several regional hospital groups, had been with the society since its origin 40 years ago. The society owns and operates California Hospital, Los Angeles, and Santa Monica Hospital, Santa Monica, in addition to operating Donald N. Sharp Memorial Community Hospital, San Diego. Mr. Heerman had for years served prominently on many local, regional and national hospital committees, particularly those concerned with insurance and legislation. A former A.H.A. trustee and a past chairman of the A.H.A. Council on Administrative Practice, Mr. Heerman also helped organize Hospital Service of Southern California (Blue Cross), serving as president of that group for eight years.


Martin Saren

Martin Saren has been appointed administrator of Long Island Jewish Hospital, New Hyde Park, N.Y. He had been acting director of the hospital since December 1957. A member of the American College of Hospital Administrators, Mr. Saren first served the hospital as assistant director. Prior to that he was assistant director of Grasslands Hospital, Valhalla, N.Y. He has a master's degree in hospital administration from the University of Minnesota.

W. Boyd Jones has been appointed administrator of Anniston Memorial Hospital, Anniston, Ala., succeeding controller **George Schneider,** who has been acting administrator since the resignation of **Harold Wetzel.** Mr. Jones has been administrator of Southeastern Kentucky Baptist Hospital, Corbin, Ky.

Osmund H. Webster has been named assistant administrator at Children's Medical Center, Dallas. He is a graduate of the Washington University hospital administration program.

John C. Neal has been appointed administrator of Jackson Hospital, Jackson, Ala. He has been administrative assistant at Crawford W. Long Hospital, Atlanta. He is a graduate of the Georgia State College course in hospital administration.

A. Robert Crawford Jr. has been named assistant administrator of City Hospital, Springfield, Ohio. Recently discharged from the air force, Mr. Crawford was medical service administrator of the hospital at Keesler Air Force Base, Keesler, Miss., since March 1956. He is a graduate of the Yale University program in hospital administration.

Dr. Harold William Conran has been appointed superintendent of Western State Hospital, Hopkinsville, Ky., succeeding **Dr. R. G. Blackwelder,** who died recently. Dr. Conran has been director of professional services for the department of mental health since last August.

(*Continued on Page* 171)

Ontario Plan Aims at Solvent Hospitals

The new insurance plan for the province of Ontario is expected to improve the financial status of hospitals, according to this article by the plan's director

David W. Ogilvie

THE government sponsored hospital insurance plan inaugurated this year by the Ontario Hospital Services Commission, a special body created to coordinate hospital services and administer hospital insurance in the province, is a combination compulsory-voluntary premium scheme. Some 5,300,000 persons, over 90 per cent of the population, are participating. Previously, about 72 per cent of the population had some degree of voluntary hospital insurance and more than half of these were in Blue Cross.

Ontario is not the only province of Canada with a government sponsored hospital insurance plan; nine of Canada's 10 provinces now have signed, or indicated willingness to sign, agreements with the federal government under which the government is sharing on a formula basis in the cost of hospital insurance in the provinces.

Under the formula, the federal government agrees to pay to each province a portion of "shareable costs" amounting to:

1. Twenty-five per cent of the average per capita costs of hospital services in Canada as a whole, plus

2. Twenty-five per cent of the average per capita costs in the province itself, multiplied by the population covered.

Three provinces of Canada — Alberta, British Columbia and Saskatchewan — have had provincially sponsored plans for some years without federal sharing in the cost. Since July 1, 1958, the date set for the introduction of the national program, the federal government has been contributing to the cost in these provinces.

The Ontario Hospital Services Commission was established by Act of the Provincial Legislature in April 1956 with two basic terms of reference:

1. To ensure the development throughout Ontario of a balanced and integrated system of hospitals and related health facilities.

2. To establish a plan of hospital care insurance in accordance with an agreement between the government of Ontario and the government of Canada.

These terms of reference are in logical order as no hospital plan can function adequately without a proper supply of hospital beds and other necessary services. It should be pointed out, however, that the commission is not taking over the hospitals of the province. Its function is one of guidance, licensing and approval. The hospitals will remain locally sponsored community institutions, dependent upon community support.

The commission, among its many and varied activities, will retain a staff of highly qualified consultants in nursing and other technical specialties whose services will be available to any hospital requesting advice in specific areas of administration.

The problem of hospital beds and facilities, of course, is a continuing one. Ontario, like other provinces in Canada, has been going through a vigorous program of hospital expansion since 1948, aided and given impetus by federal and provincial matching grants toward hospital construction. This program was given a heartening transfusion early this year when these grants were doubled by both governments. Previously each government paid $1000 per bed toward the construction of acute hospitals. Now, owing to greatly increased construction costs, these grants are $2000 from each government for a total of $4000 per bed. Administration of these grants is under the commission, through its hospital services branch. By guiding present and future construction and conducting a continuing program of research, it should accom-

D. W. Ogilvie

David W. Ogilvie is director of hospital insurance for the Ontario Hospital Services Commission. He has been associated with payment for hospital services since 1936, when he established a hospital credit service in Toronto. He joined the Ontario Hospital Association in 1947 as deputy director of its Blue Cross Plan. He has served as vice president of the Canadian Council of Blue Cross Plans and commissioner for Canada to the Blue Cross Commission of the American Hospital Association.

plish much toward the achievement of a balanced and integrated system of hospitals over the years to come.

In developing the hospital insurance plan it was the policy of the government of Ontario that all concerned with and interested in the implementation and effects of such a plan would be given an opportunity to put their views before the legislative standing committee on health. Much came out of the meetings of this committee of distinct assistance in the drafting of regulations under which the insurance plan is operating and the commission is also indebted for subsequent assistance from many hospital, medical, insurance, business and labor organizations.

The plan is universally available to all residents on a premium basis at uniform rates of $2.10 a month for a single person and $4.20 a month for families. The family rate covers husband, wife, and all unmarried, unemployed children under age 19. It also covers children age 19 or over who are financially dependent because of physical or mental infirmity. Premium income will represent approximately one-third the total cost of the plan in 1959, which is projected at about $210 million.

Full Benefits at Ward Level

It is a basic plan providing full benefits at the standard ward level. Although it provides benefits for all the hospital care which is medically necessary, the plan does not cover any outpatient services except emergency hospital care within 24 hours of an accident; neither does it provide benefits for admissions solely for diagnostic services which could have been performed on an outpatient basis.

Co-insurance deterrents were carefully studied by the commission but it was decided to omit them, initially at least. Deterrents rest on a premise of doubtful validity – that is, that only the poor, to whom co-insurance is a real deterrent, abuse the privileges. Again, deterrents are a contradiction of the fundamental principles of hospital insurance, namely the prepayment of hospital costs while well. Also considered was the fact that deterrents would weigh most heavily on those who require long-term hospitalization and who, perhaps, can least afford them. Finally there was the fact that a large proportion of the people, being insurance minded, would find a way to insure privately against the deterrents and thus nullify their value.

In providing benefits the plan pays the hospitals' operating costs but *not* capital costs. To establish per diem rates for benefits, the hospitals are required to submit budgets to the commission for the ensuing year. By dividing the estimated total operating costs by the projected number of patient days care to be covered, the commission rate board arrives at an "all-inclusive" daily rate which will be paid by the plan for insured services. The same rate must also be charged to uninsured patients. In computing costs, hospitals include the cost of semiprivate and private care and 50 per cent of the rate charged for these preferred accommodations is deductible from operating costs – the other 50 per cent may be retained by the hospitals and used for any desired purpose.

Submitted "Dry-Run" Budget

To help the hospital become accustomed to the preparation of these budgets, each hospital was requested, in 1957, to submit a "dry run" budget for the year 1958. At the time this article is being prepared, budgets for the year 1959 are being examined by the commission rate board. In studying the budgets for approval, the commission will be in a position to compare costs between comparable hospitals in comparable situations. This should prove beneficial to some hospitals as these comparisons will enable them to benefit from the experience of other hospitals if there are areas of their operation where costs are out of line. The standard ward rate struck for each hospital will be tentative. Each hospital's experience will be reviewed each year and, where necessary, retroactive adjustments, up or down, will be made.

Under the agreement between Ontario and the federal government, the federal government does not share in the cost of hospital care provided in tuberculosis sanatoriums and provincial mental hospitals. It was the wish of the provincial government, however, that these benefits be included in the insurance plan. Therefore, the whole cost of this service is being absorbed without federal contributions.

The commission will occupy the entire field of standard ward hospital insurance in Ontario. Private prepayment plans and insurance companies may sell additional coverage, such as insurance for the difference between standard ward and semiprivate or private accommodation, and medical benefits.

The citizens of Ontario have been accustomed to insuring themselves up to the semiprivate level. This has been the experience of all plans and particularly of Blue Cross, which always had from 70 to 75 per cent of its participants enrolled for semiprivate coverage. Also, this was a field for continuing service by private insurers, many of whom have seized the challenge to make many forms of supplementary coverage available to the people. In an effort to make a one-premium package available to the people, the commission offered, at cost, to collect premiums for supplementary hospital insurance and administer benefits for any prepayment plan or insurance company which desired to enter into an agreement with the commission for such service.

It was not possible, of course, for the commission to offer to collect premiums for insurance other than that to cover the semiprivate or private differential. Two prepayment plans have taken advantage of this offer, the Ontario Hospital Association's Blue Cross Plan and the Credit Union Mutual Benefit Association. Selling and servicing the semiprivate supplement is the responsibility of the insurer; the commission handles only the collection of premiums and the administration of benefits. Blue Cross and C.U.M.B.A. will issue their own checks to hospitals for supplementary services.

Prevents Over-Insurance

The plan will rule out over-insurance – a long-standing insurance problem. With the introduction of the plan, residents may have hospital insurance only for the amount actually paid for their care. The commission plan will cover the basic services, and residents may recover only the difference *paid* for preferred accommodation. Also, it is no longer legal for a resident to buy loss-of-income insurance which is contingent upon being a patient in hospital. For example, a resident may insure for payments when he is off sick, but such payments may not be increased because he is hospitalized.

In short, following the introduction

of the plan, it will no longer be financially profitable to be a patient in a hospital, and the benefits of this restriction should be reflected in incidence of admission and length of stay. In the absence of co-insurance and deterrents, the commission considers it important that no residents go to the hospital over-insured.

Participation in the plan is compulsory for all residents employed where there are 15 or more on the payroll — voluntary for all other residents. This combination compulsory-voluntary policy was adopted because of the difficulty in enforcing a completely compulsory premium program. To do this would require a very complicated system of bailiffs for collection of premiums. It was decided, therefore, to make the plan mandatory only where this could be enforced — *i.e.* with the employed groups; and the fact that no other basic hospital insurance would be available was an incentive to voluntary participation!

Provided for Needy Persons

Insurance without payment of premiums is being provided for needy persons in receipt of Provincial Public Assistance. In Ontario, the Department of Public Welfare, through an agreement with the Ontario Medical Association, has, for many years, provided free out-of-hospital medical services for certain recipients of public assistance through a medical welfare plan. These recipients include persons between age 65 and 69 who qualify to receive benefits under the Old-Age Assistance Act, needy persons age 70 or over who have passed a means test, persons who receive benefits under the Blind Persons' Allowances Act, the Mothers' and Dependent Children's Allowances Act, and the Disabled Persons' Act.

These welfare recipients will also receive hospital insurance without payment of premiums. The same applies to children in certain children's institutions and children under the care of children's aid societies approved under the Child Welfare Act. In all, some 150,000 residents are insured in this way as recipients of public assistance.

Medical necessity is the only criterion to determine eligibility for hospital benefits. This, of course, places control of the utilization of the plan largely in the hands of the medical

Provincewide Campaign Educates Public

To launch the insurance plan it was necessary to enter into a provincewide advertising and publicity program so that all residents would be aware of the benefits and provisions of the plan. Some idea as to the scope of this program is obtained when it is realized that Ontario is a very large province of 412,582 square miles (about 1⅛ times the size of Texas, but smaller than Alaska) and its people, though more or less concentrated in the central and highly industrialized southern parts of the province, are widely scattered in the northern regions where they are engaged in such occupations as mining, manufacturing of pulp and paper, lumbering and trapping.

In addition to supplying literature and other enrollment aids to employers and other prospective groups, the commission made Pay-Direct applications widely available in banks, hospitals and post offices throughout the province. Supporting this was an extremely broad educational program employing all mass media — daily and weekly newspapers, foreign language newspapers (some 17 different languages), farm papers, radio, television, outdoor posters, and interior and exterior transit cards. The program was spread over a period of 10 weeks, from the last week in July to the end of September, and during that period hospital insurance was one of the main topics of conversation in Ontario.

In addition to the paid announcements, news media received an information kit which contained releases on various phases of commission activities and the plan in particular. The development and introduction of the plan have been important news in Ontario ever since concrete steps were taken to launch it, therefore a great deal has been published about it. By far the greater part of the comment has been in support of the program.

Further public education was carried out by the commission's staff of some 50 field representatives, mainly recruited from the Blue Cross enrollment staff, who traveled the length and breadth of Ontario making personal calls on employers, speaking to such groups as Rotary, Kiwanis and Lions Clubs, Home and School Associations, and Women's Institutes, and answering hundreds of questions.

No mention of the provincewide education program would be complete without a reference to an informational film which was produced to help take care of the requests for speakers on the subject. A specially produced combination narrative and interview film of about 26 minutes in length was in great demand all during the spring and summer months. Taking into account the large number of organizations that requested it, and the fact that it was shown over all television stations, and that a recorded version of the audio portion was broadcast by all radio stations, it is doubtful if there are many residents of the province who have not either seen the film or heard the radio broadcast.

profession and it is gratifying that the Ontario Medical Association is giving leadership to the establishment of three types of medical staff committees in hospitals:

1. Admission and discharge committee
2. Utilization of diagnostic services committee
3. Pharmacy committee

It will be readily seen that organized medicine in Ontario has a firm grasp on the doctor's responsibility as the only authority who can determine medical necessity. In light of this, the Ontario Medical Association is extending every assistance in helping the doctors work together to ensure the effectiveness of the insurance plan.

Three types of group registration were employed. First, there were the mandatory groups of all persons employed where there are 15 or more on the payroll; second, employers with six to 14 on the payroll were given the option of electing to form mandatory groups for their employes and, third, collector group facilities were made available to organizations of persons who are not on a common payroll, such as professional associations, rural medical cooperatives, credit unions, craft unions, and other groups which could meet the commission's requirements. The commission offered to enter into agreements with any such group, under which agreements it was to be understood that the organization could not make a charge for the handling of insurance premiums, that remittances to the commission would be on a monthly basis, and that the person responsible for handling the group would be bonded. Although no fee may be charged for collecting the premiums, the groups are permitted to collect annual premiums in advance and remit monthly to the commission.

The most notable example of collector groups is found in the medical cooperatives which operate in the rural areas. These organizations, for the past 10 or 15 years, have been selling hospital and medical insurance to the various counties they serve. Now that their hospital insurance has been replaced by the commission plan, it was to their advantage to act as collectors for the commission hospital insurance and also sell their medical benefits to their members as part of a "package" deal. All 34 medical cooperatives in the province are acting as collectors and, in this way, not only assisting their own cause and helping the commission reach the farm population, but also affording the rural people a convenient method of paying their hospital insurance premiums.

The commission has been extremely fortunate in having a close relationship with the Ontario Hospital Association which not only represents the hospitals as a voluntary association, but also, as previously mentioned, operates the Blue Cross Plan. The association's large and efficient Blue Cross Plan was a tailor-made organization with the personnel and equipment needed for administration of the commission plan. Were it not for this fact, it would have been much more difficult to attempt the enrollment of more than 5 million residents and to plan for handling the vast number of billings, records and hospital claims which will come with the launching of the plan.

Will Work for Commission

A high percentage of the Blue Cross staff is progressively being taken over by the commission and by the end of 1958 virtually all these personnel were scheduled to be on commission work. Actually, the staff of just under 500 which Blue Cross employed for an enrollment of about 2,250,000 will be increased to about 700 to handle the commission's additional 3 million-odd residents. The relative cost of administration, however, should not be as high as the extremely low Blue Cross operating costs of about 5 per cent of premium income, as the commission plan will deal with a much greater volume and employ many additional mass technics.

The primary effect of Ontario Hospital Insurance will be on the financing of hospital care in this province. For the first time hospitals will be paid the actual operating cost of providing their services.

With more than 90 per cent of the population insured, the areas for possible loss of revenue will be at a minimum and the fact that hospitals are permitted to include in their budgets

(*Continued on Page* 128)

How Medical Staff Committees Function

The terms of reference suggested for the admission and discharge committee include:

1. Local survey of available beds with particular reference to those which might meet the requirements for acceptance as convalescent and chronic beds under the plan.

2. Review of admissions and the development of classification of admissions by categories such as emergency, semiemergency, elective, and so on.

3. Review of length of patient stay and the development of methods to expedite discharge of patients on an equitable basis.

The terms of referenee for the utilization of diagnostic services committee include:

1. Review utilization of each diagnostic service per hundred admissions for a five-year period to develop a graph of utilization over that period.

2. Starting in 1959, compare utilization per hundred admissions on quarterly basis with developed graph. If there is abnormal utilization, review utilization on individual doctor basis.

3. Act as review committee in cases that are questioned by the hospital services commission as to eligibility for coverage of diagnostic services.

The pharmacy committee would:

1. Review utilization and cost of drugs on a quarterly basis and develop graph.

2. If utilization or cost appears abnormal, do a breakdown on individual doctor basis.

Courtesy staffs as they are now organized serve no valid purpose, says the author. They should be realigned into two groups — a visiting staff of qualified, competent men and an "assistant" staff of those whose work needs supervision

What Should We Do About Courtesy Staffs?

Robert S. Myers, M.D.

WHY have a courtesy medical staff? This is a question asked with increasing frequency by physicians, particularly those who bear the brunt of hospital committee work, and by administrators who must try to allot too few beds among too many physicians. The same question is voiced by some members of the courtesy staff who resent their frequent lack of prestige and their usual last chance at the empty bed. If such is the general unhappy feeling, why, indeed, have a courtesy staff?

Undoubtedly, this same question must have bothered the hospital planners, when they first charted the course of medical staff organization. Having laid down the neat and reputable categories of honorary, consulting, active and associate staffs, these pioneers probably found themselves with a group of physicians who failed to fit into the other molds and for whom a special category must be created. This was the courtesy medical staff, whose very name implies the favor being conferred upon this group, a sentiment confirmed by the official definitions which were established to describe the divisions of the staff.

The *honorary* medical staff were nonactive physicians of outstanding reputation; the *consulting* medical staff were recognized specialists; the *active* staff determined staff policy and were the only group eligible to vote or to hold office; the *associate* staff were the heirs apparent to the active staff; the *courtesy* medical staff were those who desired to attend patients in the hospital but who, for some reason not disqualifying, were ineligible for another category of the staff. They were also the one group named specifically as a warning of the fate of erring associate members, who must attend a majority of medical staff meetings "under penalty of reverting to the courtesy medical staff."

It went even further than this; into the official literature crept the suggestion that the courtesy staff be the repository of those "who because of personality or temperamental difficulties might, if members, bring disharmony into the active staff." And finally, it was advocated openly by those in authority that beds be assigned first to the patients of the other divisions of the staff, the courtesy staff receiving the remainder, if any. By definition and by custom the prestige, privileges and responsibilities of the courtesy medical staff have been established at a level considerably lower than those of the other staff categories. This has been the cause of frequent friction.

This is not to imply that all courtesy medical staffs are a source of discontent and frustration to all concerned. There are many hospitals the courtesy staffs of which function effectively, harmoniously and to the satisfaction of the active staff, the administration, and the members of the courtesy staff. But, in general, certain unique circumstances attend these particular hospitals and are responsible for this happy situation. These are: sufficient beds in the community to accommodate the patients of all divisions of the staff; the eminent qualifications and unlimited privileges of most of the members of the courtesy staff; and their secure, active membership in other hospitals in the community.

These circumstances are wanting in the community where the beds are scarce, where the courtesy staff members are generally without specialist qualifications and their privileges consequently limited, and where they have no active staff membership in any hospital. This situation widely prevails, particularly in the large metropolitan areas, as was demonstrated by the 1951 report upon the hospital appointments of physicians in the five boroughs of New York City. This study showed that approximately one-third of the then 17,703 licensed physicians in New York City either had no formal hospital connections of any kind or had incomplete appointments, that is, ward or outpatient privileges only or courtesy privileges only for private patients. While similar studies have not been published for other metropolitan areas, it is our experience that the same conditions exist generally in the large cities. On the other hand, in the smaller communities, and in particular those with one or two hospitals only, the problem is quite different, as most, if not all, of the physicians belong to the active staffs of either or both hospitals.

Actually, the courtesy medical staff is but one aspect of the broad and vexatious problem of hospital privileges for physicians, a problem which has no simple solution and which is complicated by such factors as the

Dr. Myers is associate director of the American College of Surgeons, Chicago.

Recommendations for Upgrading Courtesy Staffs

1. Abandon the odious term "courtesy" medical staff. It carries the connotation of inferiority and is beneath the dignity of the medical profession.

2. In place of the "courtesy" medical staff, establish two categories which recognize the different talents and needs of those physicians who have been lumped together in the "courtesy" staff in the past.

Into one group, designated as the "visiting" staff or by any other term desired, put those physicians of eminent qualifications and proven competency who hold active staff appointments elsewhere. Extend to them the privileges of beds, when available, but do not require them to attend staff meetings or to participate in medical staff organizational matters.

Into the second group named, perhaps, the "assistant" medical staff, place those physicians with limited privileges and those newly appointed staff members who are serving a period of probation. Require this group to attend medical staff or departmental meetings on the same basis as the active staff and the associate staff, which also should observe meeting requirements; place the "assistants" on the various medical staff committees; see that they participate in the activities of the hospital, and give them bed privileges on a par with the active or associate staffs.

3. Adopt the attitude that the work of *every* member of the staff, and not just those in the "assistant" medical staff, needs to be evaluated continuously. Conscientious, ethical physicians with restricted privileges can do as competent work, within their limited fields, as can the most renowned specialists within their wider fields of practice.

4. Strive to be objective and impartial in the admission of young, well qualified physicians who desire to establish a practice in the community. The needs and facilities of the hospital and the community, and not the fear of competition, should count in the evaluation of their qualifications.

5. On the credentials committee of the medical staff, place the staunchest and most judicious physicians. Let them judge the appointment and the continued privileges of every physician upon the basis of training, experience, demonstrated competence, character and willingness to abide by the constitution and by-laws of the hospital.

type, size and location of the hospital, the number of beds available in the community, the number of physicians in the area and their qualifications, and the willingness of established staff members to admit well qualified physicians to the staff. In addition, the degree to which the hospital is organized to assure the highest standards of patient care influences the composition of the medical staff.

The hospital with effective medical staff organization will have committees to assess the qualifications of applicants and to recommend or deny privileges depending upon the qualifications of the individual and to promote or demote physicians according to the circumstances. The organized medical staff will have specific categories of staff positions, each of which will carry certain well defined duties and responsibilities. Of these categories, the active medical staff has traditionally carried the major portion of the work load in medical administrative matters, in the maintenance of the adequacy of patient care, and in the teaching of interns and residents. It is not strange that in return for these efforts, the active staff should regard its efforts as worthy of some special consideration as it relates to bed availability and to authority within the medical staff. Nor is it hard to understand why the administration of the hospital, which must rely on the active staff for the proper conduct of medical affairs, is usually sympathetic toward these feelings of the active medical staff. All of these factors influence the availability of staff positions, the categories assigned, and the types of privileges granted.

Generally, the one factor that counts the most in determining appointments to the medical staff is the availability of beds in the hospital. Where beds are abundant, privileges, including courtesy staff appointments, are easy to obtain; where beds are not sufficient to fill the needs of the present staff, the reverse is usually true. In some areas this latter circumstance has led the staff and the administration to limit the size of the medical staff to fit the facilities of the hospital. This causes resentment and hardship among physicians who are unable to obtain staff appointments, but the right of a hospital to determine its own needs and objectives and to organize its medical staff accordingly cannot be seriously disputed. This is precisely what is done in the "closed" hospital, in which all professional services are provided and controlled by the attending or active staff and in which there is no courtesy medical staff. It is a pattern observed by our medical school hospitals and has indisputable advantages for the treatment of patients and for the training of interns and residents.

But an alleged shortage of beds or a theoretical desire to improve standards by limiting the size of the staff should not be used by the medical staff as a blind to stifle competition from well qualified young doctors who desire to establish their practices in the community. In "open" hospitals, those which have courtesy medical staffs, with adequate beds, staff positions must be found for competent physicians in order to ensure an adequate supply of doctors for the needs of the community. It is to be expected, of course, that the work of the new staff member will be evaluated carefully for a time sufficient to establish his competence; it is also to be hoped that he will receive such supervision with good grace and will not attempt to show his superiority, real or imagined, over his mentors. This does happen, and it is just one more factor that complicates membership on the courtesy staff and makes it distasteful to all concerned.

No broad discussion of the problem of hospital privileges for physicians can disregard the question of the alleged right of every licensed physician to hold privileges in some category of the medical staff of the hospital in his community. Two main arguments

have been advanced by proponents for this hypothesis:

1. The hospital is the postgraduate school of the physician who needs its educational opportunities in order to serve his patients best. This argument, of course, assumes that the physician's work will be carefully and constantly evaluated, that he will be advised of the results of his treatment, and that he will participate actively in the administrative and clinical activities of the medical staff of the hospital.

Don't Pertain to Courtesy Staff

All of these essential conditions usually do not pertain to the courtesy staff, whose members are denied effective participation in the activities of the staff. Moreover, it must be obvious that the member of the courtesy staff who treats only an occasional patient in the hospital, who attends no medical staff meetings, and who is not required to participate in the clinical activities of the staff obtains little, if any, educational advantage from his appointment. As a matter of fact, there is evidence that members of the courtesy staff know less about medical administrative affairs than other divisions of the medical staff do and that such knowledge is directly proportional to the frequency with which they visit the hospital.

2. The personnel of the hospital (interns, residents and nurses) will benefit from contact with all physicians in the community. This argument presupposes that contact with large numbers of people automatically improves the scientific knowledge and the training of doctors and nurses. As a matter of fact, such contact may result in the hospital personnel's seeing a larger amount of bad work than good, particularly in institutions with inadequate controls of medical practice and may be distinctly harmful to the student.

Actually, the arguments for the right of every licensed physician to have hospital privileges disregard the well established legal and moral responsibility of the governing board of the hospital to exercise due and reasonable care in appointments to the medical staff. Only by its right to exclude licensed physicians who are considered unqualified professionally can the governing board be held responsible for the care of hospital patients. Licensure by the state should no more guarantee privileges than should certification by an American specialty board. Privileges in the hospital should be based upon the training, experience, demonstrated competence, and character of the individual physician and upon his willingness to abide by the constitution and bylaws of the hospital.

In any hospital that serves the best interests of the patient, effective standards of medical staff organization must be established and enforced. One such standard, the value of which has been demonstrated by more than 40 years' experience in the standardization or accreditation of hospitals, is the requirement for regular meetings of the medical staff to discuss the quality of care given to patients in the hospital.

The Joint Commission on Accreditation of Hospitals presently requires a 50 per cent attendance of the active staff only at the various staff or departmental meetings. This, of course, does not benefit the courtesy medical staff whose members do not attend and who are the very group in need of education and participation in the activities of the staff.

The exclusion of the courtesy medical staff from compulsory attendance has had a wholly unexpected effect upon membership in this group in certain areas where physicians find it necessary to hold membership in more than one hospital. Physicians are accepting active staff membership in one hospital and courtesy privileges in the others. This requires attendance at the staff meetings of only one hospital and does not handicap the other hospitals in meeting the attendance requirements of the Joint Commission. As one surgeon stated recently, "I used to be on the active staffs of four hospitals and had to attend at least four different surgical departmental meetings each week. Now I belong to only one active staff and am on three courtesy staffs. I attend only one meeting a week now and can spend more time with my patients."

In the case of this particular surgeon, this concentration of energies in one hospital is prudent and beneficial. He is a competent, qualified specialist whose work is consistently of the highest caliber. He is chief of surgery in the hospital where he holds his active staff appointment and uses his courtesy privileges elsewhere only for the convenience of occasional patients who prefer those hospitals. But his is a different case from that of the courtesy physician with no special training, with limited privileges, and without an active staff appointment in any hospital. This is the physician who needs the educational opportunities of the staff meeting. This is the one who should have a part in the committee work and in the other activities of the staff.

What is happening as a result of the entirely desirable and necessary meeting attendance requirement of the Joint Commission is the growth of the courtesy staff into an unwieldy mass of physicians of widely different training, abilities and needs. In this group we now find the qualified and recognized specialist, the physician with no special training or abilities, and the young newcomer to the staff who is serving a period of probation.

It must be apparent that a hospital regulation excusing the entire courtesy staff from attending meetings is not in the best interest of those physicians who need the educational opportunities provided by such meetings. It is also obvious that we should reexamine our traditional concept of the courtesy medical staff which, if the present trends continue, will become even more ineffective in the future.

Steps Can Be Taken

Is there a solution to this complicated problem of the courtesy medical staff? Probably not a complete or a universally satisfactory solution. For as long as we maintain a democracy, and as long as doctors are human beings, they will determine their locations for practice, in spite of bed shortages and local jealousies. Moreover, in a democracy, it is the privilege and reponsibility of the hospital to determine its staff composition and its objectives according to its own peculiar needs. But there are some reasonable and practical steps that could be taken with profit. These are shown on Page 86.

These recommendations are not a panacea; they will not please every physician or every hospital administrator. Indeed, they may require some modification to meet the needs and objectives of individual hospitals. But their general application should do much to improve the education of physicians, the morale of hospitals and to make all doctors feel they are an integral part of the hospital team. ■

True Taylor, administrator, points to caduceus design at the entrance of hospital.

Daylight Is Built In

EXPANSIBILITY is planned in the design of Jefferson County Memorial Hospital which serves the twin cities of Festus and Crystal City, Mo. The 50 bed structure was designed for 50 additional beds to be placed over the first floor patient areas, with vertical transportation to be provided by dual elevators to be installed at a later stage.

Services are close together, but separated through the use of a quadruple obstetrics, surgery, emergency and service corridor. These areas are daylighted by plastic sky domes. If a second floor is built in the future, it would not eliminate these lights as the future expansion is not contemplated over these areas.

Architects for the hospital were Hewitt & Royer, architects and engineers, Kansas City, Mo. True Taylor is the administrator.

Above, top: Entrance desk has unusual background design of stylized forms representing the various hospital functions. Above: Compact laboratory facilities are combined with pharmacy department.

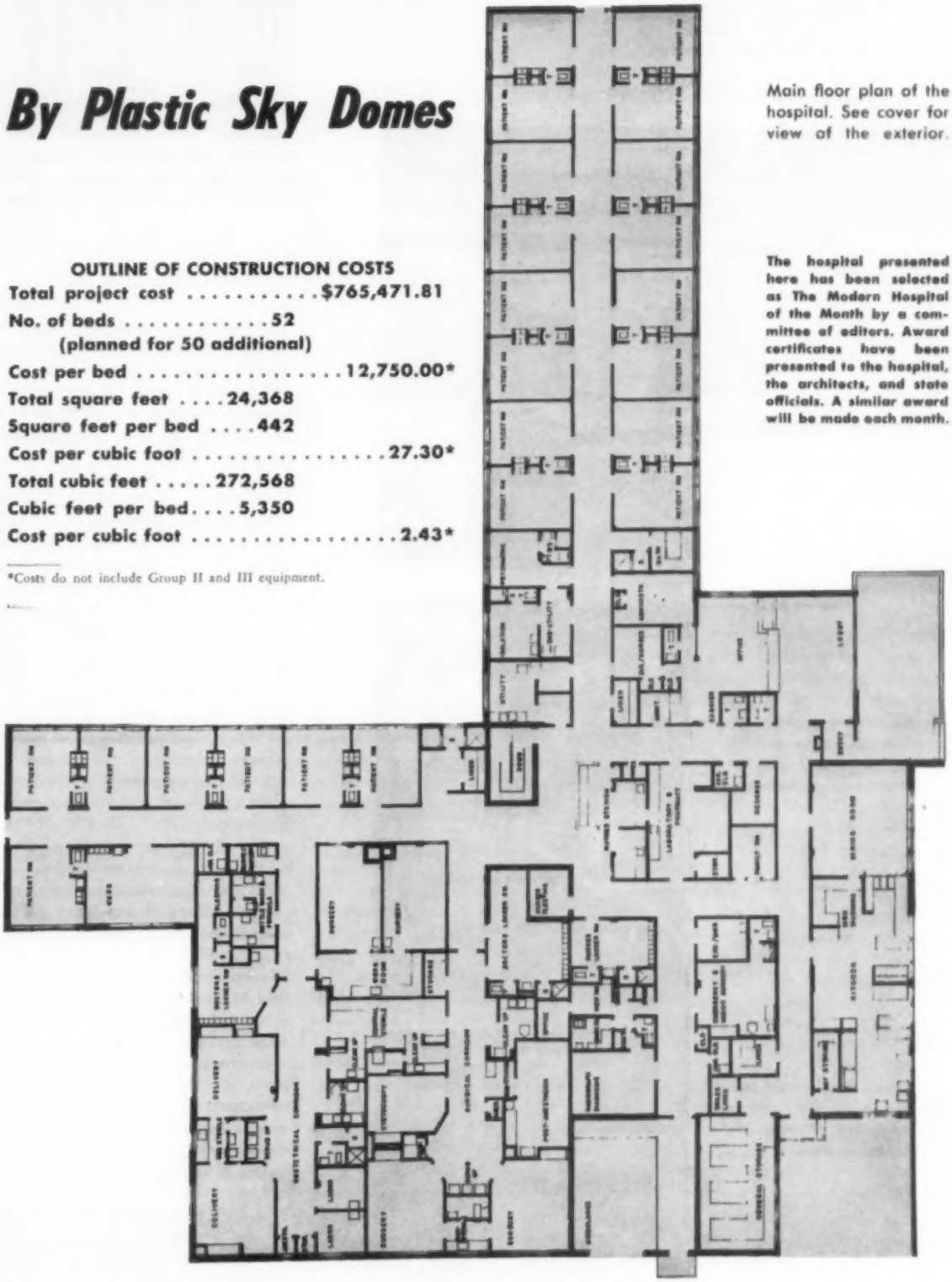
Above: Cafeteria next to main lobby serves both as a dining room and as an off-hour visitor's coffee shop. Below: Typical bedroom features glass fiber draperies, modern decor, piped oxygen, and audio-visual system.

By Plastic Sky Domes

OUTLINE OF CONSTRUCTION COSTS

Total project cost	$765,471.81
No. of beds	52
(planned for 50 additional)	
Cost per bed	12,750.00*
Total square feet	24,368
Square feet per bed	442
Cost per cubic foot	27.30*
Total cubic feet	272,568
Cubic feet per bed	5,350
Cost per cubic foot	2.43*

*Costs do not include Group II and III equipment.



Main floor plan of the hospital. See cover for view of the exterior.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and state officials. A similar award will be made each month.

Corridors are daylighted by plastic sky domes. Future expansion plan would not eliminate these sky lights.

Below: Central nurses' station with floor pantry and medicine room alcoves controls four main corridors.

Surgery, delivery and auxiliary facilities are adequate for 100 beds and could be expanded horizontally to meet increased demands, True Taylor, administrator of the hospital, explains.

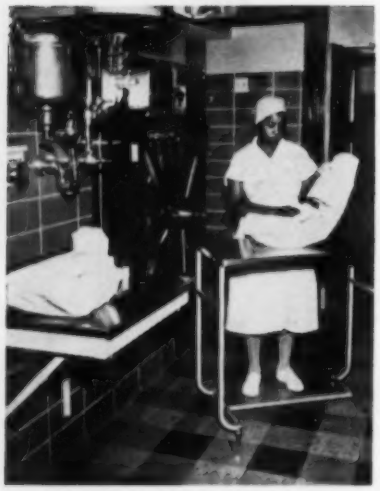
One of the interesting features of the hospital, according to Mr. Taylor, is the central nurses' station with its floor pantry and medicine room alcoves. The station provides visual control of both the obstetrical and medical-surgical entrances, the patient areas, public entrance corridors, and the entrance to the service and emergency corridors. Visual control is supplemented by an audio-visual patient communication system.

Central sterilization is located convenient to both the surgical and obstetrical departments. The dual nurseries are placed so as to be a public interest point.

The ground floor includes mechanical areas for boiler, air conditioning, and other mechanical facilities; employes' lockers and shower rooms; engineer's office and maintenance shops, and large storage areas. General hospital supplies enter the ground floor at grade level. Supplies will be sent to the main floor by elevators when they are installed.

Mechanical features include complete air conditioning by a dual temperature water system; piped oxygen throughout the hospital, and a complete sewage disposal system, required by the lack of community facilities to the site. Water is provided by a deep well, dug and piped as part of the construction contracts. An emergency electric plant is available in case of power failure. ■

Right: Central sterilizing is convenient to the surgery and obstetrical departments.



Right: Dual nurseries are serviced by common workroom, formula and bottle washing area.

Let's Give the Public the Facts About Costs

The public has a right to answers to its questions about hospital costs. Every person in the hospital organization who has contact with patients must know why costs are what they are and be prepared to explain them

Ray E. Brown

A HOSPITAL is simply the congregated personnel and equipment that the community has provided for its medical care. Therefore, the community has a right to ask questions about the hospital and has a right to expect that we will give them understanding answers. No matter who may hold legal title to a hospital, whether it be Catholics or Baptists or a nonprofit community corporation, it is a community enterprise. It represents in many instances the sacrifices of a lot of people to provide resources that the individual cannot provide for himself at home. Neither can his doctor provide these resources in his office. What we have done is cooperatively to put together those medical resources that none of us individually could provide, and certainly none of us individually could use, because the expense of such a possession would be prohibitive. So this is a community institution, and the community assumes and has great rights as far as the hospital is concerned.

Who is the hospital? To the person who uses the hospital, it is the people that he comes in contact with. It is the people who say things to him when he asks questions about the hospital. It is always true that the person who gives answers is considered to be someone who has knowledge and who has authority to give those answers. Any form of enterprise has to have someone to give answers. In other words, we have to give any activity a voice, so that the person who needs information or who is seeking advice or instructions can receive the instructions or the answers that he needs. The asker has a right to believe the answers are authoritative and factual, and that the hospital's spokesmen are speaking from a knowledge that permits them to give adequate and full explanations of the facts.

Why is there such an emphasis on hospital costs? It is no secret that hospital costs are rising rapidly. The public is pretty sophisticated about the fact we are in an inflationary period, but we are going much beyond that with our hospital costs. When this occurs, the public has a right to know why — and just idle curiosity, if nothing else, would cause it to ask questions. The number of these questions will be increased because utilization is increasing — that is, more and more people are going to hospitals. This means more and more people are being affected by hospital costs. Adding the two together, we come up with the fact that an increased percentage of the national income, or of the community's income, is going into hospital care, and therefore the community has a right to say: "Why do we have to put more of our resources into hospital care when we could very well put them into color television, or into power brakes, or something else?"

These things add up to a serious problem to the American hospital system and the way we are now financing our hospital care. As we all know, third parties are paying an increasing portion of the cost of hospital care. About two out of every three people have some form of hospital coverage. If we are passing the cost of hospital care more and more to the third-party system, it means that the well persons now are becoming concerned about what they are paying, because increasingly it isn't the sick who are paying the hospital bills, it is the well people in our communities. The sick don't like to spend money for hospital care, but at least they *were sick;* the well certainly don't want to spend money for hospital care, because they aren't sick and are not deriving any direct benefits. This is one reason increased utilization and increased costs are such a problem for Blue Cross; our hospitals have forced them constantly to raise the charges they are making to the well people of the community, and the well no longer relate the service they are getting to the payments they are making, because they aren't getting service, they are simply making payments. We have got to explain to the patient and to relatives why hospital costs have increased and why the charges that Blue Cross makes have increased, so that they can tell the well with whom they come into contact about the necessity of increased payments to third parties, and especially to Blue Cross which pays off in hospital service at increasing cost, rather than in a set amount of cash.

If hospitals are, as we say, community agencies, and if they are necessary

---

Condensed from a talk presented at the Institute on Hospital Costs conducted by the Chicago Hospital Council, November 1958.

Mr. Brown is superintendent, University of Chicago Clinics, Chicago.

How To Talk About Hospital Costs

1. Listen to what the questioner is really saying. He may be trying to tell you something as well as ask a question.

2. Realize that people who ask questions in hospitals are disturbed and therefore may not state their questions as coherently as otherwise.

3. Understand the real motivation behind the question. The person may be using one complaint to get an entirely different problem off his chest.

4. Be specific in the information you are giving. Remember that the other person often hears what he thinks you are going to say rather than what you do say.

agencies to the extent that they are tax free and receive other subsidies from government, or from the public, it must mean that they are touched with a public interest. They are not the same as a department store which might raise its prices without any public notice; they are more like the public utilities, or other regulated services. If the public becomes disturbed enough about hospital costs, it will turn to its public agencies and ask them to control what the hospitals are spending, to take jurisdiction over the right of a hospital to raise nurses' salaries, or to add new services. Therefore we must be sure we are dealing with a knowing public that will not, through misunderstanding, ask for dangerous actions to be taken, actions that would stifle the voluntary system that we believe is producing the best possible hospital care for the American public. A fully informed public is the only alternative to a misunderstanding one.

Finally, we have a moral responsibility. We are stewards of the public's equipment. The public has provided the means to bring together expensive equipment and highly trained personnel, and it has asked us to do the best job we can in maximizing the usefulness and minimizing the cost of this equipment and this personnel. If we are going to try to explain something to the public, we have got to do it with an honest face, with a conviction that we have done the best job we can, and that we are explaining a good stewardship. To attempt to explain any other sort of stewardship would be insincere and almost any person can detect insincerity.

Responsibility for stewardship extends to every hospital employe. Every employe must be concerned about hospital costs and become anxious about hospital costs. Each one is part of an activity that costs the hospital money. Each is spending the hospital's money, and has an obligation to satisfy himself that he is wringing every dollar's worth of service he can out of each dollar that he is spending. This must be true before he can explain hospital costs effectively. Each employe must also be concerned that he is doing the best sort of job he can with those parts of the resources that have been placed under his control, with those aspects of hospital care or hospital costs over which he has an influence. We have all got to accept the responsibility that we ourselves are involved in the total of operating costs in our hospitals, and that we ourselves have got to take the first steps in doing something about being sure they are as low as they can possibly be.

No matter what we do, hospital costs will continue to rise, but at the same time we will have kept them from rising to the extent that we have increased the efficiency of the operations and improved productivity. If we have done all we can do about the costs which we can control then we will be much better informed about those costs which we cannot control. We will be able to explain them because we will have studied them and worried over the answers to them.

Knowledge about hospital costs is, however, not enough. This knowledge must be effectively transmitted to those who are concerned over these costs. What we are talking about is communication; we are talking about somebody asking and somebody answering. There are two or three aspects of communication that are especially important in the hospital setting. The first of these is to be sure to listen to what the other person is saying. In the world today we just don't listen enough. We are trying to anticipate what a person is going to say. We are trying to outguess him or to read between the lines. If we are going to start giving meaningful answers we must be sure we get the question and be sure we have heard the questioner through even after we have heard the questions. We must remember that this person is usually in what is to him a strange situation. People who ask questions in hospitals are often upset over their medical condition or that of a member of their family. They are worried, they are anxious, and so they are probably not going to be as coherent or state their questions as clearly as they would if they could be as objective as we are.

Of course, every hospital employe has to develop a certain amount of callousness as to the emotional problems that people face in serious illness. We would become pretty sick ourselves if we tried to carry every patient's emotional load. At the same time that we are developing some detachment, some impersonal thinking about the people who have these troubles, however, we have got to give them credit for being disturbed. We must realize that they are asking questions in a context that makes them different individuals from what they would be if we were with them at a movie or ball game or if we were discussing some abstract question with them, like politics or the international situation.

Listening itself is hard for anyone to do, and for us in the hospital listening involves hearing the same old questions time and time again. Nobody can for long retain a genuine interest in old questions. Furthermore, the mechanics of listening are pretty difficult, because we can talk or ask questions at the rate of only 125 words a minute, and yet we can listen at the rate of more than 1000 words a minute! This variation leaves a lot of time for the listener's mind to wander. So it is awfully hard for us to pay attention, yet if we are going to have any meaningful questions asked of us, then we have

(*Continued on Page* 132)

How Methods Engineering Gets Results

The methods engineer's primary function is to train employes to make the best use of their time and skills, with the ultimate aim of carrying out the hospital's policies with maximum efficiency at the lowest cost

Harold E. Smalley, Richard A. Dudek, and Edward J. Gerner Jr.

THERE are many ways of making better use of hospital personnel. Some are scientific, others are intuitive. Managerial proficiency requires good managerial practices in program planning, fiscal management, design of functions and physical facilities, personnel practices, public relations, and professional relations.

Management engineering, which can embrace the functions of education, research and direct practice, is a tool of administration for carrying out hospital objectives within prescribed quality standards, cost goals, and administrative policy. The methods improvement practitioner does not make policy; he merely helps carry out existing policy. As a tool of management, this professional approach to organized methods improvement facilitates the execution of administrative decree. As an efficiency mechanism it strives toward maximizing a ratio of *results* to *costs*. It is within such a setting that management engineering must be viewed.

If any management tool is to serve the interests of the organization, it must make a positive contribution to management's attempt to execute administrative policy. Success or failure of a program can be expressed in these terms only. If a program helps to carry out objectives, it is successful; if it does not, it is unsuccessful. Organized methods improvement programs can be judged accordingly.

The worth of a methods program can be measured in terms of its accomplishment. Accomplishment is assumed to be equivalent to the ratio of the results to costs. Since results and costs may be high or low, accomplishment will range in value. Results are yields actually achieved, as shown in the formula on page 94.

Being the ratio of results to costs, accomplishment will increase if results increase at a constant cost; it will increase if results remain unchanged while costs are reduced, and it will increase if results increase proportionally more than costs. Conversely, accomplishment will decrease if costs increase proportionally more than results. The objective of any methods improvement program should be to maximize accomplishment by maximizing the ratio of results to costs.

Organized methods improvement

H. E. Smalley

R. A. Dudek

E. J. Gerner Jr.

Harold E. Smalley, Ph.D., is professor of industrial engineering at Georgia Institute of Technology and a consultant in hospital methods improvement. Formerly, he was assistant in health professions at the University of Pittsburgh. He is a member of the American Institute of Industrial Engineers. Richard A. Dudek is professor and head of industrial engineering at Texas Technological College, formerly research associate in the University of Pittsburgh Health Center. Edward J. Gerner Jr. is assistant to the executive director and management engineer at Children's Hospital, Pittsburgh, and is a member of the A.I.I.E.

This is the first of two articles on the subject of better utilization of hospital personnel, based upon a presentation by the authors at the Middle Atlantic Hospital Assembly, Atlantic City, N. J., 1958. The second article will be presented in a later issue.

Algebra Breaks Down the Total Cost

Cost is the whole complex of disadvantage stemming from the consumption of resources, human and material. This theorem may be expressed algebraically as: $A = R/C$. Results can be thought of as a function of magnitude, M, and quality, Q, *i.e.* $R = f(M \text{ and } Q)$. The total cost, tangible and intangible, of a method or procedure may be expressed as a function of monetary cost, C_M, and non-monetary cost, C_N. By substituting the equivalents of R and C in the equation given above, the general accomplishment equation may be stated as: $A = f(M \text{ and } Q)/f(C_M \text{ and } C_N)$.

programs mean changes – changes in methods, procedures, systems, jobs and other conditions of employment. These changes arouse suspicions, fears and apprehensions with which the methods practitioner must cope. It has become axiomatic in industrial engineering practice that technical competence is of little value without equal competence in human relations.

It is probable that hospital people are no less human than other people with respect to psychological inertia. Behavioristic and environmental factors combine to comprise a significant obstacle to the introduction of a methods program in hospitals, namely, resistance to change.

Education

One of the most respected technics for facilitating communications and overcoming resistance to a management program is education. Regardless of the technic employed, the problem of establishing a suitable climate of attitudes takes on several dimensions – direction, location and magnitude of indoctrination, as explained in the panel on the opposite page.

There are a number of problems requiring solutions before the indoctrination process is attempted. Among these are the need for a competent indoctrinator and intelligent selection of the proper educational machinery. The most popular method of indoctrination has been the short course and the most popular topic for the short course has been work simplification. This seems to be sound for the following reasons:

1. Work simplification is a natural extension of the management philosophy of methods improvement.
2. Being based upon organized common sense, its principles are easily understood by almost everyone.
3. It is a kind of nontechnical methods engineering which forms a foundation for the other segments of industrial engineering.
4. The breadth of the survey-appreciation approach used in work simplification widens the vistas of participants and sets the stage for implementation.
5. Its philosophy is noble, its objectives are compatible with hospital objectives, its methods are relatively simple, and its results are usually dramatic and easily discerned by all.

The principles that form a basis for management engineering are applicable in any line of human endeavor. Work simplification, as a part of management engineering, is no exception to this rule. However, training materials now available from other fields of application cannot be transplanted easily without change. New training materials should be devised to enable hospitals to speed up the process of indoctrination. Other problem areas pertain to instructional methods, locale for short courses, type of representation, and characteristics of short course sessions.

There are several ways of indoctrinating health oriented people in methods improvement. First, there are credit courses offered by colleges and universities for nurses, administrators and others. For example, the University of Pittsburgh school of nursing offers a two-credit course in methods analysis applied to nursing service functions on the graduate level. Similar courses are offered by other educational institutions, such as the State University of Iowa, Washington University, and Ohio State University. Another method employed by colleges is to provide guest lectures for students in the health professions. These are directed toward students in hospital administration programs and in schools of nursing, dentistry, pharmacy and medicine.

As a part of certain academic courses, methods improvement projects are undertaken as term papers. One such project is a study at the University of Pittsburgh School of Nursing in testing the reliability of a patient profile that measures the degree of dependency of the patient upon hospital personnel. Another is a class project interviewing patients on the comfort aspects of the hospital bed.*

Of course, many hospitals engage in methods improvement projects regularly. Also there are certain health oriented people with sufficient motivation to become preindoctrinated by guided study, without the aid of formalized classes. Recently a graduate student in nursing made herself quite proficient in the technology of work sampling, a technic not ordinarily mastered by a nurse.

Another way of achieving indoctrination is through short courses or institutes. The hospital may organize its own courses or it may send selected representatives to other institutions.

Some hospitals may elect to send representatives to established management courses, such as those at the State University of Iowa, University of Connecticut, and Purdue University. Some may want their people to attend regular college courses and some may elect technical institute training. Regardless of the means used, it is essential that indoctrination must be carried out successfully and the short course appears to be an excellent mechanism for providing this prerequisite to implementation.

It is apparent that this all-important indoctrination process can be achieved through education. However, educa-

*Smalley, Harold E.; Dudek, Richard A.; Dinnerstein, Albert J., and Gailani, Dorothy M.: An Investigation of the Hospital Patient Unit Progress Report, U.S.P.H. Project, University of Pittsburgh, March 1958.

tion must go hand in hand with research and practice.

Research

Education for better utilization of hospital personnel should be supported with research. Through research the hospital can gain a great deal by increasing the utilization of its resources, such as personnel, materials, equipment and finances, and by a better application of knowledge. The hospital can also contribute to society through research by the extension of knowledge. In the paragraphs to follow, research will be discussed from the standpoint of what research the hospital should and can do and how a research program in industrial engineering can be organized and utilized.

In general, research is a systematic search for unknown facts and principles. This general concept can be broken down into two types, these being basic or pure research and applied research. Basic research is usually defined as research for its own sake without regard to its ultimate use, or as the determination of new knowledge many times with no specific goals in mind. Applied research, on the other hand, is research for a definite, practical purpose, an investigation with the intent of utilizing results to achieve a given practical purpose. Types of research can be considered as a continuum, the two ends of the continuum being basic research and applied research. Many research projects lie within these extremes, *i.e.* having some characteristics of each type.

To clarify these definitions further, an example will be drawn from a project being conducted at the University of Pittsburgh, sponsored in part by the United States Public Health Service, namely that of a cranking experiment to determine the best kind of crank for the hospital bed. There is much existing information in the literature which indicates the criteria for cranks when used on jobs requiring speed and accuracy. If the job of positioning the springs of the hospital bed required speed and accuracy, this available knowledge could be adapted to the cranks for a hospital bed. This process of adapting existing knowledge to a specific problem at hand with subsequent testing would be applied research. However, it is apparent that the major criterion for hospital bed cranks is not speed and accuracy

How To Win Acceptance of New Methods

Indoctrination of personnel on all levels to any proposed management program has three essential elements: direction, location and magnitude.

Direction

There seems to be no reason to doubt the validity of the principle that programs must be "sold" from the top down. If methods improvement is to succeed, it must be supported by those in high organizational positions. This principle assumes that sympathy and support can flow downward but not upward. This seems to be consistent with the teachings of industrial management with respect to the proper direction of indoctrination: In hospital methods improvement, this principle would seem to start with the administrator, if not the board of trustees.

Location

There is the question of who in the organization must be "sold." Indoctrination of the administrator alone probably is not enough, although indoctrination of all personnel may be unnecessary to achieve reasonable results. The consensus of those contacted in a recent study* indicates that indoctrination should be located in administration, nursing service, department heads, and supervisors. Additional research and experience would seem to be needed in order to gain more knowledge about this dimension.

Magnitude

There would seem to be several degrees of indoctrination. Progressing from one end of a continuum to the other, the lowest degree might be "lip service." Here the person gives the appearance of sympathy and support but actually is indifferent or even opposed to methods programs. Next, there is "faith." This involves a belief in the objectives of the program without knowledge as to the program's assumptions or methods. A bit farther up the scale is "appreciation." This magnitude of indoctrination could be thought of as an awareness of objectives, methods and results. Then comes "understanding," which is characterized by discernment and comprehension of methods work in its entirety. "Technical competence" includes understanding as well as the skills required for practicing methods engineering. Finally, the top of the scale is reached at the "professional competence" level. At this apex most of the skills are retained but understanding is broadened by virtue of education and experience in the total discipline (industrial engineering) of which methods engineering is a part. Of course, one might rank philosophical, ethical and moral competence even higher, but perhaps these go beyond the parameters involved here.

There is no reason to assume that a hospital must establish a given level of indoctrination for all personnel. It is possible that a "faith" level is sufficient for board members but an "appreciation" level is necessary for department heads, supervisors and, perhaps, medical staff. The administrative officer who coordinates the program might need an "understanding" level, while practitioners would have to have "technical competence." The individual responsible for directing the program should be in the "professional competence" category.

*Smalley, Harold E.; A Study of Work Simplification in Hospitals With Emphasis Upon Economic Implications. University of Pittsburgh, June 1957.

but rather the performance of work with ease and safety. Thus the problem reduces to one of determining the optimal combination of crank variables to perform a given amount of work, *e.g.* pounds pull, crank radius, torque and number of turns of the crank. Such an experiment, developed to extend knowledge about cranks, even though there was a specific goal in mind, would be basic research.

Many times these types of research are performed concurrently. If a basic research project is undertaken, at various stages it may be necessary to perform applied research. In the same way, if an applied research project is undertaken there may be stages at which basic research is required.

In general, industrial engineering research done by the majority of hospitals is confined to applied research. Most of the basic research is done by university medical centers and by private research organizations. Many hospitals are actively engaged in industrial engineering research. Examples of this research are listed below.

Applied. In a large general hospital, an industrial engineer made tests of ultrasonic cleaning of surgical instruments, hypodermics, and so on.

In a rural general hospital a test was conducted to see if a home washing machine could be used for cleaning rubber gloves.

In many hospitals industrial engineers have verified manufacturers' specifications of equipment and material in the business office, laundry and other departments.

A university medical center is undertaking a cost project studying disposable versus reprocessed hospital supplies in an attempt to adapt the *make or buy* principle utilizing the operations research approach to the problem of selecting between these two types of supply items.

Basic. At the University of Pittsburgh, the bed project is being done to determine optimal characteristics for the general purpose hospital bed.

The State University of Iowa Hospitals are conducting studies concerning the preplanning of nonrepetitive work.

Quality of patient care studies are being conducted at Ohio State University.

In beginning a research program, it is best that it be started with short, easy problems. Many times no concrete results are immediately apparent and therefore difficult problems which require much time may come to be regarded as an unnecessary expense item. Of course, administration must guard against becoming shortsighted if a research program is desired. This should not be difficult for hospitals to accept for many hospitals have research as a policy mandate along with the mandates of taking care of patients and providing a service to the community. Most of this research performed in hospitals is in relation to health problems. But with a slight extension of policy, industrial engineering research could also be performed. The method used in the research should be left to the professional industrial engineer who has been trained in scientific methods.

To determine how a research program should be introduced one can draw on psychological research dealing with motivations and goals of individuals. It must be recognized that both positive and negative motivations exist. The positive motivation is the desire to extend knowledge or the desire to solve a given problem. The negative motivation is the work that must be expended to achieve these goals and the inconvenience the research project may entail.

Human beings react negatively to new programs if the barriers or detours are too great at the outset. This reluctance on the part of people, sometimes called *resistance to change*, is to be found in education, research and application. Therefore, a research program or any new program must start slowly with meaningful goals; the problems which should be undertaken first are those with "quick payoffs."

Research can lead to better utilization of the resources of hospitals, to better application of knowledge, and to the extension of knowledge. Research is not an end in itself. Like education, the true worth of research is realized in practical applications. How research can be put to practical use, with illustrations of work that has been done along this line, will be discussed in the concluding section of this article in a later issue of The Modern Hospital. ■

Increased Automation Predicted as Step Toward Methods Improvement in Laboratories

New York. — The rapid increase in bed capacity of hospitals has placed a burden on hospital laboratories that can be relieved only by automation, it was reported here recently.

In an article published in *Analytical Chemistry*, Dr. Samuel Natelson, head of the department of biochemistry, Roosevelt Hospital, said that the "sheer numbers of analyses that have to be performed daily" had increased proportionately with the increase in beds.

"To meet this problem there is an active movement toward automation of procedures most commonly performed," Dr. Natelson said. "One approach has been to automate each step in the procedure. The last ten years have witnessed a remarkable development in instrumentation and technics, with a drastic move toward microprocedures for the routine laboratory of clinical chemistry."

Dr. Natelson said it is "obvious" that automation will be accelerated during the next ten years.

The article dealt with detailed information about the automation of analytical chemical procedures in hospital laboratories. "Improved understanding of the significance of levels of numerous components in body fluids and tissues in the diagnosis and treatment of disease has resulted in a demand that the clinical chemistry laboratory be prepared to determine these components," Dr. Natelson said. "This has stimulated a rapid development in analytical technics and upgrading quality of personnel to supervise and perform laboratory procedures."

Dr. Natelson said the hospital problem was complicated for the analytical chemist by the necessity for determining numerous compounds appearing in body fluids and tissues, by the limited amounts of fluid and tissue available for study, and by the need for making determinations rapidly.

"Results must be made available rapidly enough to help in the treatment," he said. "This requires that procedures be direct and require a minimum number of transfers."

Why Medical Care Costs Concern the Senate

As chairman of a subcommittee investigating hospitals and Blue Cross in Washington, Senator Wayne Morse, in this Modern Hospital interview, says the inquiry might become nationwide, and airs his views on the costs of health care

George E. Connery

SENATOR WAYNE MORSE, Oregon Democrat, loves a fight and he can't understand why other people don't always feel the same way. "When it's over you have more facts on the table and you have a much better chance of getting something done," he explains.

Now he is wading into an issue that may develop into a long-range argument with doctors and hospitals over the financing of medical care costs.

Technically, the question at the moment is a relatively narrow one — whether the commissioners of the District of Columbia (Washington's "city council") should appoint a majority of the board that controls the D.C. area's Group Hospitalization, Inc. (Blue Cross). The Senator is chairman of a subcommittee that is looking into the matter.

But actually the issue is not that limited geographically. National attention seems to focus on most situations in which Senator Morse becomes involved, and this is no exception. Furthermore, if the Washington hearings produce information of broad significance to medical care costs, Senator Morse, through his membership also on the labor and public welfare committee, could swing out into a national investigation.

"Certainly that's a possibility," he told The MODERN HOSPITAL, "but it's not the only possibility. Foundations and other organizations outside government might take some action, too."

Senator Morse is one of the Senate's foremost authorities on constitutional law and legislative procedures. He has promised that hearings will be conducted strictly by the book, that he will show no preference. And no one who knows him would doubt that.

Yet he is not a legal automaton; he has some strong views on the responsibility of the federal government for getting proper health care to all the people at prices they can afford. For this reason it is important to understand the beliefs that have projected him into a prominent position in hospital-medical legislation.

Advocates Forand Bill

He is the Senate's most articulate advocate of the Forand bill, and has introduced an identical measure in his chamber. This is a proposal to raise social security taxes to finance hospitalization for the aged and other beneficiaries of the system. It is being vigorously opposed by the American Medical Association; American Hospital Association's opposition is something less than vigorous.

He doesn't see any way short of state or federal subsidies to bring hospital and medical charges within the reach of all the population.

He is not in the least awed by the political strength of the medical profession and hospital people. "Organized medicine is against me almost all the time. But they haven't done much damage. All I have to do is make a few speeches on the subject of medical costs, and line up a few facts, and I don't have to worry."

Yet, to him it is not paradoxical that it was his vote on the Senate labor committee that for three years kept the Wagner-Murray-Dingell socialized medicine bill bottled up.

"I was against socialized medicine then and I'm even more opposed to it now," he says. "Actually, the doctors ought to realize that it's liberals like me who talk up to them who are their only real friends and who are the only ones who can save them from government control."

Senator Morse, a former law teacher, can point specifically to the Constitution of the United States as his guide in almost any controversy that arises.

In this situation, he quotes the preamble:

"We the people of the United States, in order to form a more perfect union, establish justice, insure domestic tranquility, provide for the common defense, *promote the general welfare* . . . . do ordain and establish this Constitution for the United States."

"The principles of government must be implemented," he insists. "The general welfare, the promotion of the general welfare, is a duty and a responsibility of the Congress.

"This also means checking any power that is inimical to the welfare of the people. I am anxious to protect

medicine's legitimate rights, but I'm not going to let the doctors or the hospital people write their own laws or stop us from writing the proper laws.

"Like all other laws, laws affecting medical care and medical costs and research and public health are laws for all the people, not just laws for the doctors and the hospitals. They are not going to be allowed to dictate laws that apply to the whole population, no more than labor is going to be allowed to write the labor laws that apply to the whole population.

"The doctors can't write their own ticket down here.

"In many of these situations the trouble comes because people — and members of the Senate included — are not able to apply abstract principles to concrete problems. The Constitution says plainly that the Congress is to promote the general welfare. This is our source of authority to pass laws that we think will improve the medical care the people are getting. But many people can't see that relationship and that obligation.

"In more specific terms, the health of the American people is a great source of wealth. The government cannot sit idly by and see it destroyed."

The Senator, naturally, doesn't accept the argument of organized medicine that rapid progress is being made in bringing good medical care to all the people.

Should Be No Variation

"I am not satisfied that the equality of health treatment is being attained. There is no reason why in our times there should be a variation of medical care based on families' various economic positions."

The Senator's opinion that health legislation and medical care are important issues with the people was reinforced, he said, by the results of an informal survey taken by his office early this year.

The Senator's newsletter had reached a circulation of 60,000. It was an expensive operation, and besides he suspected that there were too many people on the list who shouldn't be there, and that there were wrong addresses, etc. So a "sudden death" notice was sent out. If the readers didn't return the enclosed form within a certain time their names automatically would go off the mailing list. Also, on the form there was a space just labeled "Comments."

Of those who wrote any comment, Senator Morse said, a preponderance were concerned over the high cost of hospital and medical care. Why did costs have to be so high? Why were health insurance rates always going up? How do you get the money to pay for a long illness? The usual questions, of course, but their volume was surprising. Only one other subject — worry about a war — produced anywhere near as many questions as did medical care costs.

This was a straight, unrigged response. No subjects were suggested, nor were any even listed on the form.

No Room for Doubt

If the Senator had any question about whether he was moving into an important field, one in which the people's concern was vital, that question was now removed.

"I was intrigued by the fact medical costs and war fears resulted in far more comments than all other subjects combined.

"Why these two? I think it's an expression of basic insecurity in the face of illness and war. In either case, the individual family has little or no control over its fate. There are two major and frightening specters — national devastation through an enemy attack and personal devastation, financial and physical, through an attack of illness."

The record over the last year shows Senator Morse is driving right ahead in his investigation, and that, eventually, he probably will have all the facts spread out on the table where he wants them.

The first District of Columbia hearings last summer were prompted by announcement that Group Hospitalization, Inc., would raise its rates by about 42 per cent. Senator Morse called on all interested parties to explain.

In opening the session, the Senator remarked that he was fully aware that the problem had "far broader aspects" than the raise in rates. "This deals with the whole question of the direct and indirect rights of citizens in the field of medical care. And may I say for the benefit of the medical profession that this is something the American people are going to be confronted with more and more, year after year."

Later, in questioning one of the District commissioners, the Senator again took a look far ahead when he said: "Whatever information we have to get we are going to get, because I think this is the proper place to point out that the American people in the years ahead, I think, are going to expect their government to see to it that the health of the people of this city receives adequate care at reasonable cost."

The commissioners then explained that they wanted Congress (which must pass all laws for the District) to pass a bill to give them authority to name a majority of the board members (hospital and medical appointees now have majority) to keep close and constant check on Group Hospitalization's operations, and to approve or disapprove rate changes.

Group Hospitalization's spokesmen put up a strong defense — there had been only three prior rate increases in 25 years, and two reductions; the group lost almost a million dollars the previous year; 65 per cent of its expenses are wages and salaries.

The increases went into effect in the fall, and it might be the subscribers were more understanding of costs than the commissioners and the Senators, because last year there were 5000 fewer cancellations than in the previous year.

Called for New Ideas

That hearing settled nothing. After a lull of several months, Senator Morse announced that hearings would be reopened early this session. Also, to keep the fire burning, he challenged the District doctors to get busy on the problem, to accept their responsibilities, and to come up with some new ideas.

That elicited a sharp reaction from the District of Columbia Medical Society in the form of a statement written in obviously restrained rage. It said in part:

"It can probably honestly be said that we as a society have been seriously studying such problems (as medical care) a much longer time than most people who are at present loudly proclaiming that the doctors must supply the answers to the causes, and find the solutions of the 'high cost of medical care'. . . .

"All we want for ourselves is reasonable compensation for the years of education, the staggering expense of the

same, the proficiency we have acquired through long hours of dealing with the sick, the constant night vigil of study, and attending at considerable expense medical meetings and postgraduate courses. The main compensation we receive is the satisfaction of helping suffering humanity, but we too must live and rear and educate our children."

Then, with rage translated to satire, the editorial continued:

"We know that we and other physicians and scientists are partly responsible for the 'high cost of medical care' in that we have developed expensive diagnostic procedures and therapeutic modalities to cure sick people quickly that were not known 50 or even 25 years ago. On the other hand, we are not responsible for the alarming inflation that has caused our efforts to be so costly. We respectfully submit that the latter is the main problem for our politicians and statesmen to solve. . . ."

It is unlikely that Senator Morse, inured by years of long-range and short-range exchanges with doctors, was much impressed.

His reaction was a change of pace, for which he is noted.

He Thanked the Committee

Ignoring the charges, he thanked the society for its cooperation, and with his letter enclosed a copy of another letter he had sent to a publication. The latter said in part:

"I intend, and I am sure that my colleagues on the subcommittee intend, in this inquiry to be guided by a major principle which should be at the basis of any congressional inquiry. That principle is simply to determine what the facts of the situation are in order that a firm record may be made which can serve as a basis for legislation which is in the public interest.

"It is not our intention to 'pillory' any individual or group of individuals. At the same time we have the duty and responsibility of makng as thorough a study as we can in order that the relevant factual material can be placed upon the public record. We will follow where the facts lead, and the legislative product will reflect what we find. . . ."

That appeared a reasonable and a moderate approach. But it should not be interpreted as a change of heart. Wayne Morse still is convinced that the people are not getting the health care they should, and that it is the responsibility of the federal government to move in rapidly and forcefully and correct the situation.

He is still standing firmly on his creed, as expounded when he introduced his version of the Forand bill.

"It is simply economic nonsense to continue to assume that our older people, hard-pressed in the best of health to make ends meet on the shrinking purchasing power of the pension dollar, can squeeze enough extra dollars from this meager income to meet the mounting cost of really adequate health protection. Clearly they cannot. . . .

"Let us not wait upon an administration that is decades behind the times in recognizing and coming to grips with social and economic problems. The Congress has the primary obligation to consider this legislation, to perfect it, and then to enact it."

Yet, when asked more about his views on the Forand-Morse bill, the Senator said:

"This may not be the way to do it. Maybe there is another way. But at least we should get down to concrete facts."

Remember, he's the one who for three years kept the socialized medicine bill off the floor of the Senate. And he would do that again. ■

Senator Morse Takes the Prize for Showmanship

This lawyer-farmer-educator-Senator is 59 years old and vigorously healthy. He neither smokes nor drinks, and it's hard to see how he would find time for either diversion. It is not unusual for him to get up at dawn, drive an hour out into Maryland, exercise a horse, or work with his cattle, then be back for a full day in the Senate and a full evening of dining and speaking. People are subjects to him, something to be studied and pried into, even those he doesn't like.

His office is lined — literally — with ribbons and trophies won at cattle and horse shows. He thinks nothing of loading a horse into his ultramodern horse trailer and taking it clear across the country. Once when he was taking cattle to a fair he decided at the last minute to take along a Dark Brahma rooster and see how he'd do in competition. He won first prize. At a horse show he was competing with gaited horses. There weren't enough entries in a jumping class, and he was asked if he had a horse he could enter. He mounted a gaited mare (they're not supposed to jump), and took second ribbon.

Born in Wisconsin, Senator Morse taught law at the University of Wisconsin and the University of Minnesota. He was dean of the law school at Oregon when he went into politics. The record shows he left the Republican party and entered the Democratic. His story is that there was not much of a change in him because most of the Democrats were for him and most of the Republicans against. In the Senate he's never really relaxed; his razor tongue is always well honed and ready to lash out. He is not known to have backed out of any situation just because his critics wanted him out.

Senator Morse and his horse

A Conference Is As Good As Its Leader

No matter what the purpose of the conference may be, its success or failure depends largely on the leader's ability to plan the agenda, to draw everyone into the discussion, and to end the session on a positive note

Leonard Nadler

A MAJOR objective of a supervisory training program is to help the supervisor make the most effective use of conferences. Inasmuch as the leader is probably the most significant member of the group, the training aspects of conferences will center on "conference leadership." This is not to minimize the role of the other people who take part in the conference. However, in most work situations the conference leader is also the supervisor. Therefore, in this supervisory training program it is only natural that the focus should be on the supervisor as a conference leader.

There are several subsidiary objectives to this training conference. It is important to consider why we have conferences and to examine the roles of those who take part in conferences.

Before proceeding further it is probably necessary to have the group agree on just what is a conference. This is another one of those words referred to in a previous article as possibly having a rather special meaning for hospitals. In general hospitals the term "staff conference" is fairly common and usually denotes the meeting of the medical staff. In mental hospitals the term that one might meet is "case conference." Although these are definitely conferences they are not the kind of conferences we are considering in this training program. It will be obvious, however, that some of the concepts and experiences shared during this training conference might well feed back to the other kind of conferences. Here, however, we are concerned more with those conferences called by a supervisor with his subordinates.

A good way to get discussions started is for the training conference leader to ask: "What is a conference?" Usually, this evokes quite a bit of response. However, if it should not, any good conference leader should be prepared with a set of alternate questions to produce discussion. Therefore, the conference leader might further ask: "Have any of you ever taken part in conferences?" It is fairly unbelievable that there would not be some kind of affirmative answer. If there is, the conference leader can build on this by asking the members the common elements of the different conferences they had attended.

The descriptions and definitions of a conference would probably include the fact that it is people who are meeting together for a specific purpose. It would probably also be obvious that within the group there is a leader. Some conferences have large numbers of persons attending, whereas, if we talk about conferences between supervisor and subordinates, it is possible that the group would be small. If it is a well organized conference it will probably have a definite task.

The task of the conference may not be obvious at the beginning but it is important that the training conference leader indicate the necessity for having all members of the group understand the objective of the conference.

Conferences may be thought of in several different categories. Sometimes it is not necessary to designate specifically what kind of conference it is so long as the objectives are clear. However, at other times it is important that the nature of the conference be spelled out fairly completely. Some of the conferences that might occur in a hospital situation are:

Information. This is the type of conference where the supervisor has information to give to the subordinates. It might involve a change in personnel policies, or the announcement of the arrival of new staff members or new equipment.

Fact Finding. This is where the supervisor is attempting to obtain information from the group. It might be part of the problem solving process discussed in the February issue of The MODERN HOSPITAL or merely an attempt to find out from the group members how they have handled a particular situation. Although it is called fact finding it is also a form of information gathering. For example, if a change in pharmacy procedures is anticipated, the supervisor might call his subordinates together to tell them of the change and to get their ideas and suggestions. It should be empha-

This is the seventh in Mr. Nadler's series on training supervisors. Mr. Nadler is chief of the training division, Division of Personnel, Pennsylvania Department of Public Welfare, Harrisburg.

sized that this type of conference has a specific limitation. The group is not being asked to decide whether or not the change should be made. Presumably, this is out of its area. All the employes are being asked for is an opinion that may or may not reflect itself in the ultimate decision.

Decision Making. In this type of conference the group knows that it is being asked to arrive at a decision. Merely sharing information will not be sufficient as its task is to come up with a specific decision or recommendation. Once again, it may be a decision that must be approved by a higher authority such as the administrator. However, when a group is called together and informed that it is asked to make a decision we presume that the administrator has given the authority to make the decision that will be implemented.

Planning. This type of conference unfortunately is not used extensively enough in our hospitals. We have people with tremendous experience but we too seldom ask them to be involved in planning. One area in recent years which has encouraged the use of the staff in planning has been in the development of disaster plans for hospitals. Unfortunately, many planning conferences bog down because there is not general agreement among the group that its function is to plan, rather than to share information or to make a decision.

Training. This is the type of conference described in this series of articles. Note that in this conference the leader is not presumed to have all the information and is therefore not giving information. Also, it is not a fact finding conference and certainly is not expected to make any decisions, although it might pass on some suggestions to a higher level. It is certainly not the function of the training conference to plan. This limits the area of a training conference to the discussion of specific subject matter with the purpose of improving the job performance of those involved.

Within any conference situation there are "roles" that the various participants have. As used in this sense, the word "role" indicates the function of a particular individual within the conference setting only. Outside of the conference his role in the hospital may be entirely different. During most conferences the roles of the individuals remain fairly constant. However, in a more mature and cohesive group it is always possible to shift roles without necessarily destroying the conference.

The most significant role is probably that of the *leader*. This does not mean that this is the only role or that it is the most important. However, most poor conferences are the result of inadequate conference leadership. Therefore, it is extremely important that the leader be carefully chosen and adequately prepared. Inasmuch as the leader is usually the supervisor, it is not a matter of choosing a leader but

Pointers on Conducting a Good Conference

THE conference leader should have a planned agenda. This would be a list of the topics to be covered. Whenever possible, the suggested agenda should be sent to everybody before the conference so that all will be adequately prepared. Before the conference meets and during the first minutes of the meeting a conference leader might ask whether the agenda is acceptable to the group. Note that in this training conference the objectives of the conference have been stated in the first two or three paragraphs of this article. The limitations of the printed page do not allow for the readers (who are the participants) to let me (who is the conference leader) know if the objectives are acceptable to them. In a regular training conference it might be best to ascertain if the group accepts the objectives of the conference. In some hospitals, all agendas must be passed on by somebody from the administrative staff. If this is the case in your hospital then you should be sure that the group knows of the limitation. Do not let the members think they have the choice of agenda items when it is actually something that has been ordered from above.

One of the most significant functions of the conference leader is to plan the conference. The success or failure of the conference can depend upon the time of day and the day of the week it is held. Obviously to conduct conferences during visiting hours in a mental hospital would be almost assuring failure. During this time, the staff usually has many additional functions and is concerned with the general public as well as the patients. In a general hospital, the time of the conference might have to be regulated to allow for times when the outpatient clinic is open or other situations requiring mobilization of personnel to the full extent. Most conferences should start and stop on time. In a hospital, strict attention to the starting time is important. To run over the closing time can do much to give everybody a negative attitude concerning conferences.

Particularly with adults, the physical facilities are extremely important. Uncomfortable chairs have caused conference leaders almost as many headaches as uncomfortable verbal situations. Most of us find that if we are not physically comfortable we cannot possibly participate to the fullest extent. (For discussion of physical facilities please refer to the first article of this series which appeared in the September 1958 issue.)

When conducting the conference, the leader must be aware of many factors. A fundamental course, such as this, cannot possibly investigate all the aspects of conference leadership which are desirable. However, it might be pointed out that one of the keys to a good discussion during a conference is the ability of the leader to question. The leader must be sure that everybody has the opportunity to contribute to the conference to the greatest extent. Sometimes this can be done by utilizing buzz groups as is suggested during these training conferences. At other times, allowing for responses to questions will suffice. Other situations may call for various other training technics. ■

rather of developing our supervisors into the best conference leaders possible. The conference leader should know his group. If the members are all his subordinates there is no question about this as any supervisor should know his subordinates. However, it may be that the group also includes people from the outside. Particularly in our mental institutions where they are beginning to use patient committees, very frequently the supervisor finds himself conducting a conference with a group that includes patients as well as employes. If it is a planning conference it might well include employes from other units of the hospital as well as the leader's own. On the superficial level the use of name tags and name plates will at least let people know who is attending. At other times it might even be necessary to start with short introductions, each person giving his name, title and function.

Should Know What's Next

At the end of the conference, the leader should be sure that everybody knows what comes next. For these training conferences, the preview of coming attractions appears toward the end of the session. The group is told what the topic will be for next week. In some cases, specially prepared material will be handed out to the participants to prepare for next week. In other situations, the conference leader might distribute material obtained from other sources such as pamphlets or books.

For still other kinds of conferences, the participants might go away with specific work assignments that will be part of the follow-up on this conference and possibly in preparation for the next conference. It is important that the conference end on a positive and specific note rather than just dwindling off with the conference members slowly exiting from the room. Even if the conference has been a failure, and even the best conference leader has some of these, the conference session can be closed on a positive and affirmative note.

Numerically the largest group in a conference is the *participants*. It should be recognized however that the participants are not those who merely come to a conference and sit listening to the conference leader or some other status person. Every person who sits around the conference table has a function to perform if the conference is to be successful. The list of responsibilities for the conference participants, or group members, is quite lengthy. Some of these are that the participant should listen thoughtfully to others. Unless we are prepared to listen to the others in a conference it is difficult to learn. It is true, of course, that while we listen to others we will be evaluating in our own terms. For example, if the conference leader talks about the fact that we are going to have to expand our facilities to house 10 per cent more patients than we now have, each member of the conference will see this differently. The business office may see it in terms of increased income; the admission service may see it in terms of increased workload. This does not mean that these two points of view are incompatible. It does mean that somewhere during the conference the participants have to listen to the others and be prepared to suggest how they may all work together.

During a conference everybody should speak as freely as he can. If the climate is such that there is the constant fear of reprisal after the conference is over, the conference leader might discontinue the conference until a more favorable climate can be encouraged. Speaking freely, however, does not mean that we have the right to interrupt others or to monopolize the conversation. Each one of us thinks that what we have to say is extremely important, but the other fellow's point of view should also be given a thorough airing.

It is not intended that all conferences be sweetness and light. It is expected that there will be disagreements. If possible, the disagreements should be kept under control. This is not always possible but it should always be the goal. In the final analysis, the success of the conference depends upon the participation of the group members and their acceptance and awareness of the material discussed.

There may be times when it becomes desirable to have an outsider attend the conference in order to bring the group some special kind of information. This *resource person* can come from a number of places and offer many different kinds of service to the conference group. The use of resource people in conferences is almost unlimited. For the faculty in the school of nursing it might be advisable to bring in a professor from a local college to talk on "Principles of Guidance and Counseling Technics," for example. At other times representatives from several of the drug concerns might come in to discuss some of the newer drugs with the nursing groups. Hospital suppliers are usually quite eager to have some of their staff attend hospital conferences to discuss the products that are available.

Although resource people have much to contribute they should not be used indiscriminately. They should be chosen carefully because they have special knowledge or are authorities who can make a contribution to a conference. We are justified in bringing these persons in from the outside when the information or the skill they have is not obtainable from conference members. This means that there will be times when a particular conference might bring in persons from other parts of the hospital or from outside the hospital. The conference leader, or whoever is planning the conference, should be sure before using somebody outside the hospital that this will not serve to antagonize an equally capable person who is currently on the hospital staff. When a resource person is used the mechanism of the conference should be so constructed as to make maximum use of him. If possible, and if the resource person is available, he might remain in the hospital for the entire day and be generally available to those who wish to discuss particular aspects of his specialty that might not be of concern to the general group.

May Need a Recorder

There are two other roles that might be found in conference groups. Whether they are used or not would depend upon a variety of factors. Where it is desirable to maintain a record of a conference it is sometimes customary to use a *secretary* or *recorder*. The secretary is used when what is wanted is almost a verbatim report of what has gone on during the conference. Aside from the need for a written record for board meetings and the like, it is questionable that a secretary is the role needed in most of the conferences discussed in this article. The recorder, on the other hand, is used to keep notes of the general agreements or disagreements arrived

(*Continued on Page* 134)

Conducted by Mary P. Huddleson

Food service employes at this Veterans Hospital are given step-by-step instruction in tray assembly by means of lantern slides developed in the hospital

They Make Their Own Visual Training Aids

Gloria E. Jorgenson

GOOD orientation is important in training a dietetic service employe for efficient work. Every hospital dietitian has the same problem when it comes to obtaining visual aids suitable for the training program. There are few films or illustrative materials geared to the hospital problem. Most of the available films or filmstrips concern restaurant or office problems which have to be adapted to the hospital. It is upsetting to the average kitchen employe, whether he is scrubbing the floors or supervising the service, to have to transpose his problem from the restaurant or office situation. Few of them are capable of doing so. The lesson is lost because the background or setting is foreign to the employe.

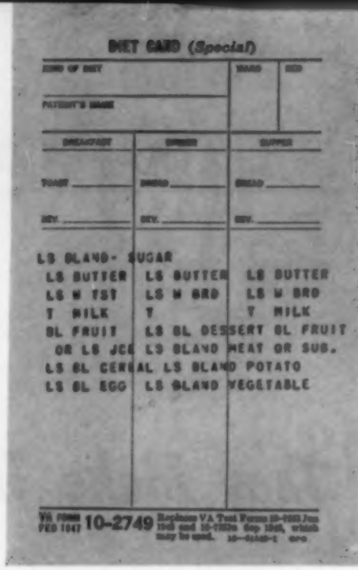
Through the years, the dietary service at Veterans Administration Hospital, Portland, Ore., has felt a great need for better visual aids. Little by little these training tools have been developed. The most outstanding and helpful aids that have been made are the colored lantern slides discussed in this article.

One of the major jobs of a dietetic employe is to participate in a tray assembly line for each meal served. The dietetic service has concentrated its efforts on training the employe for each position on the tray line. There are three positions, 1, 2 and 3. Each position is taught separately and an employe learns each new position after he demonstrates that the first position is well learned and with a minimum of errors. Position 1 starts the tray assembly line. The tray is put on the counter; each tray is identified with a tray card, and the required silverware, cup and saucer, salt, pepper, sugar, bread plate, cream and butter are placed on the tray. Individual tray assembly line instruction is given to each new employe after he has been on duty a day. If more than one employe enters the service at one time group instruction is given.

The nurses' dining room is used for the classroom. The lantern slide projector is borrowed from the medical illustrations laboratory, a blackboard and screen combination unit is on the wall, individual menus and a step-by-step instruction sheet for tray line Position 1 are handed to each employe participating in the class. The employes group themselves around the lantern slide projector facing the

Pictures of completed trays are posted on tray assembly line. For breakfast tray, below, the fork is placed next to knife to eliminate unnecessary handling of fork because it is in the way when hot food is transferred to cold tray.

On dinner or supper tray, below, fruit and salad positions are reversed as it is more convenient to put ice cream on cold trays when they are in the conveyor carts if dish is on outside; therefore, same position is kept all times.



DIET CARD (Special)

LS BLAND- SUGAR
LS BUTTER LS BUTTER LS BUTTER
LS W TST LS W BRD LS W BRD
T MILK T T MILK
BL FRUIT LS BL DESSERT BL FRUIT
OR LS JCE LS BLAND MEAT OR SUB.
LS BL CEREAL LS BLAND POTATO
LS BL EGG LS BLAND VEGETABLE

10-2749

Above: Every special diet is printed on a "Special Diet Card," as shown above, by the use of metal address plates. The 50 different plates can be modified a number of ways, *i.e.* low calorie, low sodium, and bland. LS refers to Low Sodium, Bl to Bland, TsT is Toast, T is Tea, JCE is Juice, W is White, BRD is for Bread, SUB is Substitute. Items are always placed in same spot.

Reproduction of several colored lantern slides used to demonstrate each procedure are shown in black and white on this and next page. Slides are used with a step-by-step description of the three positions. Lettering on slides indicates which hand to use for each procedure. For tray Position 1 the procedure is: Take tray from stack and set on counter. Straighten napkin and place card on tray. For breakfast, give menu, if needed. Read card. Place silverware on tray. Left, top: Take fork in left hand and knife and spoon in the right with knife blade turned toward the left. If a soup spoon is used, it is placed in the center as the teaspoon fits better beneath the cup and saucer. Place cup and saucer in lower right hand corner (left, center), pick up salt, pepper and sugar in right hand and bread plate in left. Then place cream with right hand, butter in left. For position 2, dinner or supper, read card or menu. Use tongs to pick up bread in right hand (left, bottom). Place jelly, either hand.

Tasty and thrifty soups, sauces, entrees

made with Cream of Celery Soup from *Campbell's*

SOUP SPECIALTY

Here's a creamy new vegetable soup you can serve as your specialty of the house—Campbell's Cream of Celery Soup, with your own mixed vegetables added. Of course, you can also serve rich, flavorful Cream of Celery Soup by itself, or enhance it with your choice of garnishes.

Suggested menu description:

CREAMY VEGETABLE SOUP

A smooth, creamy soup . . . chock-full of your favorite garden vegetables . . . and gently simmered to blend their flavors.

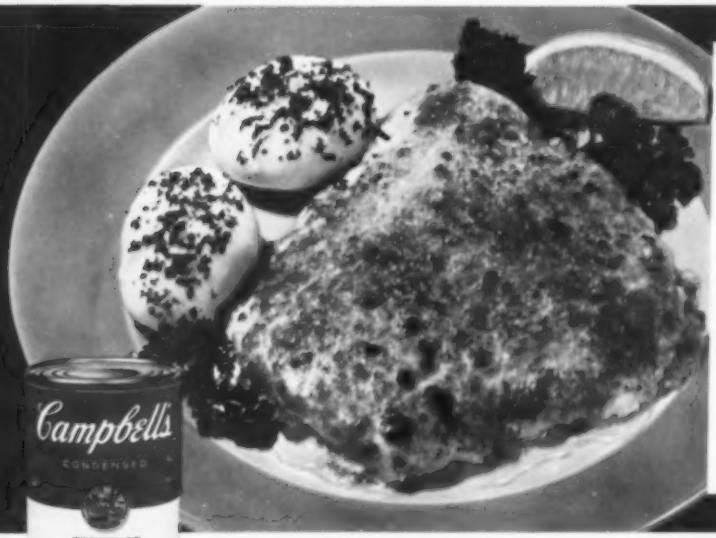
PARSLEY SAUCE

A marvelous dress-up for a hot turkey sandwich. This easy, economical sauce is made with one 50-oz. can of Campbell's Cream of Celery Soup combined with 2 cups of milk and ¼ cup of minced parsley. Garnish is cranberry-orange relish on a peach half.

Suggested menu description:

HOT TURKEY SANDWICH SUPREME

Slices of tender turkey on toast points . . . covered with a creamy parsley-celery sauce . . . on the side—a peach half, filled with tangy cranberry-orange relish.



TIMESAVING RECIPE INGREDIENT

BAKED FISH AU GRATIN. Made easy because the master seasoning is contained right in the binder (Campbell's Cream of Celery Soup). Much costly, time-consuming preparation is eliminated. Accurate portion control is easier to achieve, and you can work with small batches if necessary.

Suggested menu description: GOLDEN HADDOCK FILLET DINNER. Deep-sea fillet baked to a golden brown in a satin-smooth, creamy celery-cheese sauce . . . with parsley potatoes.

Recipe: Portions: 50 4-ounce servings plus 2 ounces sauce.

INGREDIENTS	MEASURE AND WEIGHT
haddock fillets	12 lbs.
flour	2 cups (8 oz.)
Campbell's Cream of Celery Soup	2 cans (3-lb. 2-oz. size)
shredded process cheese	4 cups (1 lb.)
chopped parsley	¼ cup
paprika	dash

METHOD

1. Cut fish into serving pieces; dip into flour; arrange in single layer in 3 greased baking pans (12"x18"x2").
2. Spread soup over fish; sprinkle with cheese, parsley and paprika.
3. Bake in moderate oven (350°F.) for about 45 minutes.

Campbell's **CREAM OF CELERY SOUP**

Campbell's makes 18 kinds of 50-oz. soups and 15 kinds of individual-service-size soups.

For quantity-recipe cards showing many other timesaving ways to use Campbell's Soups, write **CAMPBELL SOUP COMPANY • Camden 1, N. J.**

Above: Employe picks up milk in left hand, straw in right. If tea is called for, she picks up bag in right with tongs.

Left hand used for juice, right for ice, with tongs. When reading selective menu, juice is placed on tray last.

screen with the instruction sheet and menu in their laps. The dietitian introduces the class and explains to the employes that the colored slides were made in the kitchen and they will be seeing some of their supervisors as demonstrators. A slide is shown for each step and it is discussed, with the reasons given for each unusual procedure, why the fork is placed near the knife instead of the usual conventional left side of the main plate, for example. (When hot food is transferred from hot tray to cold tray the fork was always getting pushed beneath the plate so it was decided to put the fork next to the knife to save unnecessary handling of the fork and to keep the tray looking neat.)

After all of the slides for Position 1 have been reviewed and discussed, the employes discuss the evening menu and individual diet differences as to salt, pepper and sugar. The bread plates have a dual purpose: to hold bread and also to serve as a cover for soup. Regular butter and low sodium butter are differentiated by cutting off the corner of the paper butter chip. Cleanliness is especially emphasized in handling silver and dishes. It is the responsibility of the employe on Position 1 to check for cleanliness of the dishes and silverware put on the trays.

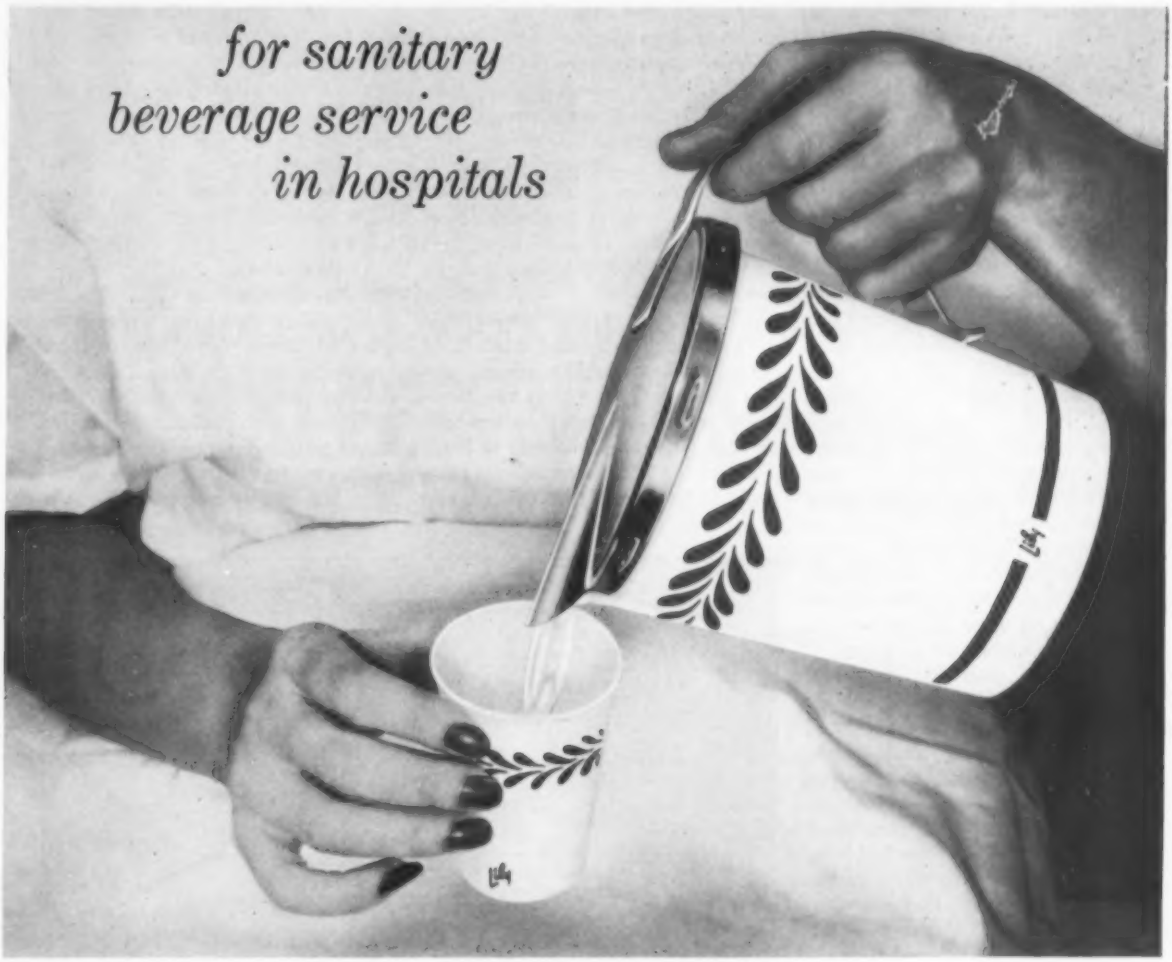
The employes are given the following day's menu for regular, bland and low sodium menus with instructions to study for preparation to work on the assembly tray line in Position 1 at the noon meal. The next day the employe is trained on the tray assembly line with complete supervision. The following day the employe is given more responsibility on the tray line and by the third time he needs little or no help working the position. Of course, it means continual daily study of menus by the employe and practice on the tray line during times other than meal hours, *i.e.* developing dexterity in picking up salt, pepper and sugar packets with one hand and in a neat, orderly fashion. After the employe has successfully mastered the position and has a greater appreciation of his responsibility for efficient tray service he is given a review of the colored slides. A similar method of training is followed for Positions 2 and 3.

Our medical illustrations laboratory made our colored lantern slides of the tray assembly line service. The dietary department drew the plans and the laboratory did the photography. The slides were developed for use in both centralized and decentralized tray service and can be easily adapted to any hospital. Eye and hand coordina-

Dessert and salad are put on at same time if neither has an accompaniment which requires the use of both hands.

Right hand is used to put on meat accompaniment while left hand adds crackers to nearly completed cold tray.

NEW LILY* DISPOSABLE WATER PITCHER



This handsome quart-size disposable pitcher assures a fresh cup of water or other cold beverage for the patient. This new pitcher pours easily, is light in weight when completely full, and will not tip even when empty. The stainless steel lid-handle unit snaps on, fits snugly over the top of the disposable pitcher and is readily removable for sterilization. The lid is designed to let liquids flow freely, keep ice in. The pitcher itself is a natural insulator and will keep ice and water cool and refreshing for hours.

This new pitcher is available in the traditional Lily Green Leaf Design to match Lily Cups...a perfect combination for sanitary disposable bedside beverage service.

For more information, mail this coupon today.

LILY-TULIP (Lily Cups)

*T.M. Reg. U.S. Pat. Off.

Lily-Tulip Cup Corporation
Dept. MH-5, 122 East 42nd Street
New York 17, New York

Please send me information on Lily's paper products for institutions.

NAME_____

COMPANY_____

STREET_____

CITY_____ STATE_____

Gloria Jorgenson is supervisory dietitian at Veterans Administration Hospital, Portland, Ore. She has a bachelor's degree in home economics from the University of Nebraska. She was on the dietetic staff at Christ Hospital, Cincinnati, for two and one-half years, until she joined the medical specialists corps in the army, when she was assigned to Fitzsimons Army Hospital, Denver. Mrs. Jorgenson joined the Veterans Administration in 1952 at Madison Tuberculosis Hospital, Madison, Wis.

tion was emphasized as well as sanitation. We have five different types of tray cards or menus and the training had to be planned to fit all situations.

Every special diet is printed on a special diet card by means of an addressing machine.* There are 50 different metal address plates and each can be modified a number of different ways, *i.e.* low calorie, low sodium, bland and so on. The same abbreviations are used throughout the system and the items are always placed in the same spots so the employes can learn their position and depend upon the item always to be in the same position, thus eliminating unnecessary reading. Employes are trained with this in mind; they learn to spot-read selective menus the same way.

The selective menus are printed on different colored paper to designate regular menus (white), bland (green) or low sodium (yellow). In addition, there is a regular diet card for patients who are not on a special diet but who are unable to select their own food.

The project was interesting and everyone thoroughly enjoyed helping with the production of the colored slides even though regular dishwashing and cooking had to continue around the stage. One problem encountered was having the same items available each time a picture had to be retaken and having the tray identical to the one on the slide that was taken the previous week. Paper supplies differ from time to time; bread and milk contracts were awarded to different companies during the photography, making the wrappers vary. These are a few things to keep in mind if you attempt the same project. Dishes must be the same and the design must be arranged the same each time.

The cost of producing the slides was comparatively low. The employes were especially interested in making the slides and have shown continued interest in using them. The supervisory food service workers were the "actors" and food service workers enjoy seeing their supervisors rather than a dietitian in the actual work areas. The dietitian supervised the actual photography. Another advantage of making the slides in the employes work area is that the employe doesn't have to visualize himself in a foreign situation. He is at home and he can concentrate on the step-by-step instruction.

The training of new employes is more thorough today than it has been. A new employe is able to recall a picture more easily than he is able to recall a printed fact, but if he has both he can't go wrong if he tries to learn. The training of new employes is more uniform because of the colored lantern slides and supplemental mimeographed material. Any dietitian can conduct the class if the regularly scheduled training dietitian is on vacation. The orientation of new employes doesn't have to be discontinued because of a lack of training personnel. The supervisory food service workers can be trained to continue the classroom training as well as on-the-job training. The procedure is specific. Everyone teaches the same way. An employe doesn't become confused when several people train him or correct him. The standard routine is set up and everyone follows it.

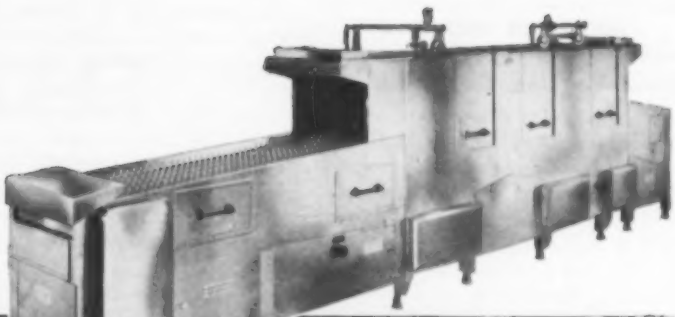
The development of the colored lantern slides is just one phase of our training. We have others. We try to have the employes participate in the activities as much as possible. Our baker, Clabe Ellett, who has been with the hospital since it opened in 1928, has completed a set of animated drawings to represent the Basic 7 food groups. He enjoyed doing it and the other employes have gained more knowledge about the Basic 7 from his drawings than from any other chart. They point with pride at the work of one of their coworkers. It is fun to develop new training aids when enthusiasm is shown by everyone. ■

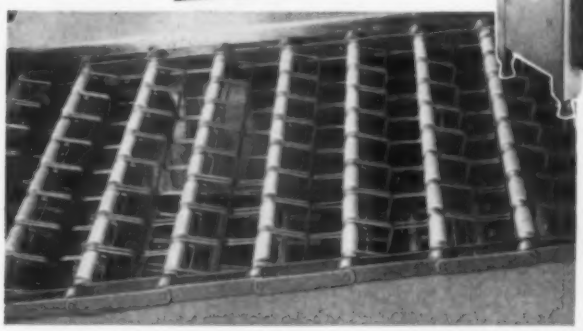
Photos courtesy Bruce D. Stuart, assistant chief, Medical Illustrative Laboratory

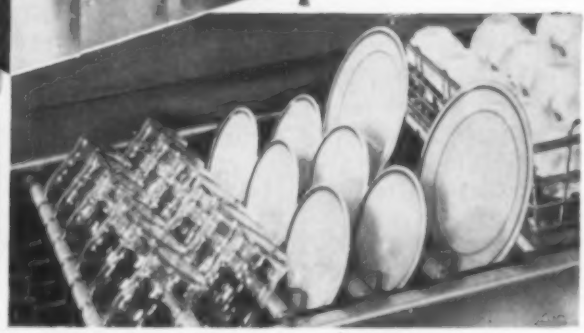
Tray line position 3 begins with the employe calling the diet to the cook. The instructions tell her to hold card up so cook can see lips move, and to speak clearly. She places beverage pot, checks the cold foods and condiments. When the hot food is delivered she checks it, covers it, and puts it on food conveyor. Tray assembly ends when cold food tray is placed on conveyor.

*This method was developed by Olive C. Carlson, assistant chief, dietetic service, Veterans Administration Hospital, Portland, Ore.

Another FIRST!





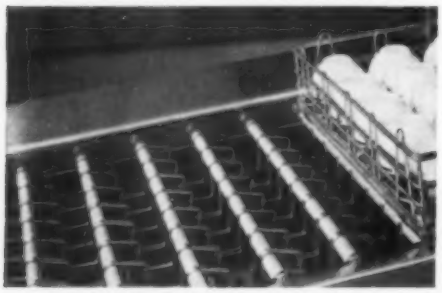


The New Dual-Purpose UNDERSLUNG Stainless Conveyor* Exclusive in

BLAKESLEE PT SERIES DISHWASHERS

Available at Same Price As Peg-Type or Flat Conveyors

NOTE POSITION of cups, plates, and trays for thorough washing, rinsing and draining.



NO PROJECTIONS above conveyor to be damaged by rack loading or unloading.

- **Combines the advantages of Peg-Type and Flat-Belt conveyors.**
- **Handles dishes and trays individually, as well as loaded glass racks and silver baskets.**
- **Virtually indestructible.**

Here's the versatility you've been looking for! With this new conveyor, you can place dishes, trays and bowls directly in the conveyor linkage . . . load glass racks and silver baskets directly on it . . . or use a combination of both!

New-formula nylon spacers on stainless steel cross rods cushion trays and dishes. Design offers minimum obstruction to lower wash and rinse sprays. Arrangement of conveyor links combines strength with minimum dish contact. There is no pull or strain to bend links out of shape. The weight is carried by stainless steel cross rods mounted in Ni-resist rollers.

Exclusive with BLAKESLEE, the new UNDERSLUNG stainless conveyor has no projections above the cross rods . . . conveyor *cannot* be damaged by loading or unloading of loaded racks.

This new exclusive conveyor is available as an optional feature at the same price as the famous Blakeslee Peg-Type and Flat-Belt nylon conveyors in any of the four PT Series Dishwashers.

* PATENT APPLIED FOR

G. S. BLAKESLEE & CO.

NEW YORK • LOS ANGELES • TORONTO

Department 117-J
1844 So. Laramie Ave.
Chicago 50, Illinois

See us at the NRA Show, Booths C44 to C54.

For additional information, use postcard facing Cover 3.

FOOD FOR THOUGHT

How To Use Dry Milk

Instant nonfat dry milk is advantageous for use in hospitals because it is easy to prepare, convenient to store, and provides an economical way to add nutritive value to foods prepared with it, according to Catherine Turner, assistant professor of home economics at the University of Alabama.

She offers several suggestions for using the dried milk.

Milk is a source of essential minerals, proteins and B vitamins, but instant nonfat dry milk is lower in calories than whole milk and can therefor be used to advantage in diets requiring a low calorie content, she suggests. The nutritive value can be increased by adding an extra amount of powdered milk when it is reconstituted. The increase may be as much as one-third cup of powder per quart of liquid.

The dry milk can be reconstituted when liquid milk is needed for any recipe. In baking and other food processes where dry ingredients are used, the milk can be mixed with the dry ingredients and water added in the amount of the milk required by the recipe. Some food service managers prefer to reliquify at one time all the milk they estimate will be needed for the day, while others reconstitute it by the recipe.

Miss Turner suggests that dry milk be bought only in quantities and packages that will keep in good condition for the time it will be stored.

The U.S. Department of Agriculture offers these suggestions for storing dry milk:

Store milk powder in a cool, dry place, preferably not warmer than 75°F. It should keep this way on the shelf for several months. Nonfat dry milk keeps somewhat better than whole milk powder.

If milk powder is put in the refrigerator, it should be transferred to an airtight jar or can.

Whenever dry milk is stored, the container should be tightly covered. Milk powder takes up moisture and gets lumpy if exposed long to air.

Fluid milk made from milk powder needs to be kept cool, clean and covered just like any other fluid milk. It should be kept refrigerated.

Freezing Meat

The importance of scrupulously clean and prompt handling of meat for freezing is stressed by the U.S. Department of Agriculture to those who are putting meat in freezers.

In tests with samples of pork in frozen storage for 12 weeks, it was found that many bacteria that cause deterioration or spoilage of meat survive or even increase in frozen storage. This disproves the old widespread belief that freezing kills bacteria. It was found that some bacteria survive in a dormant stage and then may increase after the meat thaws and warms up. Still others are not affected by freezing, even at zero °F, and may contribute to such deterioration as rancidity of pork fat during freezer storage.

The only way to be sure of a low bacterial count on meat that comes out of freezer storage is to have the bacterial load low on the fresh meat to be frozen. This calls for careful sanitation — clean, cold, fresh meat; clean hands, tools and wrappings, and a clean surface for cutting and preparing the meat. Also helpful, the department said, is keeping the meat cold before and after freezing. ■

GO ELECTRIC

for Cooler, Cleaner, More Efficient and *More Economical* Food Service!

TWO HEAVY-DUTY OVEN SERIES TO MEET YOUR BAKING AND ROASTING NEEDS!

Whatever your oven requirements, Toastmaster meets them . . . *electrically!* Two versatile series—a complete selection of 54" two-pan and 36" one-pan models—let you bake, roast to perfection . . . cut your meat shrinkage *as much as 15%!*

54" COMBINATION OVENS—Full two-pan-size sectional bake and roast ovens stack one above the other—offer "Build-On" versatility in 9 combinations. Bake section has smooth one-piece core plate deck, eliminates hot and cold spots. Roast section has pebble-steel deck to assure fast, uniform heat transfer to each square inch of pan surface. Exact heat control . . . automatically! Heavy insulation in each unit provides maximum heat retention—greater economy—and gives the coolest, cleanest cooking possible.

3-Deck Model
H541B2R
1 bake section (top),
2 roast sections
(bottom units),
insulated base.

2-Deck Model
H541B1R
1 bake section (top),
1 roast section (bottom),
insulated base, legs.

Single-Deck
Model H541R
1 roast section,
insulated base, legs.

36" "ALL-PURPOSE" OVENS

Compact one-pan size "All-Purpose" ovens for baking and roasting. 1, 2 and 3-deck stack-ons save space—offer dual bake and roast convenience in one unit. Reinforced rigidized pebble-steel deck insures exact heat over entire area, prevents burning.

Pre-set temperatures thermostatically maintained. Extra-thick insulation for maximum heat retention. Accommodates standard roasting and baking pans. Oven rack doubles capacity.

3-Deck Model H363R
3 "All-Purpose" sections, insulated base.

Also available in 1 and 2-deck models with insulated base, legs.

The Complete Line of Electric Cooking Equipment

TOASTMASTER

McGRAW EDISON

"TOASTMASTER" is a registered trademark of McGraw-Edison Company, Elgin, Illinois

TOASTERS · BUN TOASTERS · SANDWICH GRILLS · BROILERS · FRY KETTLES · GRIDDLES · GRILLS
HOT-FOOD SERVERS · HOT PLATES · OVENS · RANGES · WAFFLE BAKERS · FOOD WARMERS

Menus for June 1959

Dorothy C. Goodin
Director of Dietary Department
Thomas D. Dee Memorial Hospital
Ogden, Utah

1
Pineapple Chunks
Scrambled Eggs
•
Roast Beef, Gravy
Whipped Potato
Buttered Spinach
Spring Salad
Orange Chiffon Cake
•
Minestrone Soup
Italian Spaghetti
Buttered Fresh Carrots
Head Lettuce With 1000 Island Dressing
Fruited Gelatin With Whipped Cream

2
Sliced Orange
Soft Cooked Egg
•
Roast Turkey, Gravy
Parsley Buttered Potato
Buttered Fresh Asparagus
Pineapple and Pear Salad
Cantaloupe Wedge
•
Split Pea Soup
Meat Loaf, Gravy
Buttered Brussels Sprouts
Vegetable Cottage Cheese Salad
Peach Tapioca Cream

3
Apricots
Scrambled Eggs
•
Chop Suey, Rice
Buttered Zucchini Squash
Tossed Green Salad, French Dressing
Vanilla Ice Cream
•
Navy Bean Soup
Hamburger on Bun, Pickle, Mustard
Buttered Green Beans
Congealed Carrot and Pineapple Salad
Bread Pudding With Lemon Sauce

4
Half Grapefruit
Link Sausage
•
Roast Veal, Gravy
Whipped Potato
Baby Green Lima Beans
Relish Plate
Angel Food Cake With Strawberries
•
Creole Soup
Beef Stew and Vegetables
Citrus Fruit Salad With Celery Seed Dressing
Chocolate Nut Pudding

5
Applesauce
Scrambled Eggs
•
Grilled Halibut
Whipped Potato With Cream Gravy
Buttered Broccoli
Coleslaw
White Cake With Caramel Nut Frosting
•
Clam Chowder
Baked Macaroni and Cheese
Buttered Beets
Hawaiian Fruit Plate
Orange Sherbet

6
Cantaloupe Wedge
Soft Cooked Egg
•
Swiss Steak, Gravy
Steamed Potato
Buttered Corn
Grapefruit and Stuffed Prune Salad
Vanilla Pudding With Whipped Cream
•
Beef Noodle Soup
Creamed Vegetables on Toast
Broiled Tomato Slices
Deviled Egg Salad
Fresh Banana

7
Fresh Strawberries
French Toast, Sirup
•
Baked Ham
Steamed Rice
Buttered Green Peas
Jellied Harlequin Salad
Black Walnut Ice Cream
•
Cream of Tomato Soup
Beef Biscuit Roll, Gravy
Buttered Fresh Asparagus
Stuffed Celery
Chilled Grapefruit Half

8
Banana
Soft Cooked Egg
•
Breaded Veal Cutlet, Gravy
Whipped Potato
Broccoli and Cheese Sauce
Tomato Salad
Coconut Cake
•
Split Pea Soup
Ham Loaf, Cream Sauce
Buttered Spinach
Pineapple Salad With Avacado Mayonnaise
Lemon Junket

9
Canned Plums
Sausage Pattie
•
Escalloped Chicken
Harvard Beets
Mixed Green Salad
Banana Cream Pie
•
Cream of Celery Soup
Braised Tenderloin Tips With Mushrooms
Stewed Tomatoes
Head Lettuce With Chiffonade Dressing
Fruit Cup

10
Prunes With Orange
Soft Cooked Egg
•
Rib Roast of Beef, Gravy
Whipped Potato
Parsley Buttered Carrots
Congealed Lime Cabbage Salad With Fruit Dressing
Fresh Strawberry Ice Cream
•
French Onion Soup
Tomato, Cheese Macaroni
Buttered Green Beans
Rolled Banana Salad
Chocolate Cake

11
Fruit Cocktail
Crisp Bacon
•
Roast Leg of Lamb, Mint Jelly
Steamed Potato
Buttered Brussels Sprouts
Minted Pear Salad
Coconut Butterscotch Pie
•
Navy Bean Soup
Tuna Noodle Casserole
Buttered Zucchini Squash
Relish Plate
Pineapple Upsidedown Cake

12
Apricots
Scrambled Eggs
•
Baked Filet of Salmon
Escalloped Potatoes
Buttered Baby Green Limas
Coleslaw
Peach Cobbler
•
Tomato Noodle Soup
Toasted Cheese Sandwich
Buttered Mixed Vegetables
Sliced Orange and Avocado
Pineapple Sherbet

13
Apricot Nectar
Breakfast Ham
•
Roast Pork Loin and Applesauce
Whipped Potatoes, Gravy
Buttered Spinach
Stuffed Peach Salad
Oatmeal Cookie
•
Fresh Vegetable Soup
Spanish Style Meat Balls
Buttered Fresh Asparagus
Tossed Green Salad
Fresh Grapes

14
Fresh Orange Juice
Hot Cakes With Sirup
•
Fried Chicken, Gravy
Buttered Rice
Buttered Frozen Green Peas
Congealed Cherry Nut Salad
Chocolate Ice Cream
•
Cream of Green Bean Soup
Salisbury Steak, Gravy
Buttered Corn
Tomato and Cucumber Salad
Danish Dessert

15
Fresh Strawberries
Soft Cooked Egg
•
Broiled Lamb Chop
Baked Potato
Creamed Carrots and Celery
Sliced Orange Salad, Fruit Dressing
Lemon Layer Cake
•
Tomato Bouillon
Beef Stew, Dumplings
Buttered Green Beans
Pineapple and Cottage Cheese Salad
Butterscotch Pudding

16
Applesauce
Scrambled Eggs
•
Turkey Pot Pie
Whipped Potatoes
Harvard Beets
Relishes
Cheese Cake With Crushed Pineapple Topping
•
Cream of Green Pea Soup
Barbecued Spareribs
Buttered Broccoli
Caesar Salad
Fresh Fruit Cup

17
Half Grapefruit
Link Sausage
•
Braised Liver and Onions
Au Gratin Potatoes
Stewed Tomatoes
Chef's Salad
Peach Ice Cream
•
Pepper Pot Soup
Eggs a la King on Toast
Baby Green Lima Beans
Banana and Pineapple Gelatin Salad With Fruit Dressing
Chocolate Brownies

18
Canned Figs
French Toast With Sirup
•
Breaded Pork Chop
Spanish Rice
Buttered Zucchini Squash
Sliced Tomato Salad
Baked Apple
•
Cream of Potato Soup
Salmon Loaf, Cream Sauce
Potato Chips
Buttered Green Peas
Hawaiian Fruit Plate
Velvet Crumb Cake

19
Fresh Cherries
Soft Cooked Egg
•
Grilled Haddock
Whipped Potato, Cream Gravy
Buttered Green Beans
Cabbage, Pineapple, Green Pepper in Lemon Gelatin Salad
Chocolate Eclair
•
Clam Chowder
Macaroni and Cheese
Buttered Spinach, Lemon
Spring Salad
Raspberry Sherbet

20
Purple Plums
Hot Cakes With Sirup
•
Baked Ham, Mustard Sauce
Baked Potato
Parsley Buttered Carrots
Apricot and Cream Cheese Salad, Chopped Nuts
Butterscotch Pudding
•
Creole Soup
Meat Loaf, Gravy
Buttered Fresh Asparagus
Citrus Fruit Salad
Oatmeal Cookies

21
Fresh Strawberries
Sausage Pattie
•
Roast Turkey, Gravy
Whipped Potato
Broccoli, Hollandaise
Mixed Fruit Salad
Vanilla Ice Cream
•
Navy Bean Soup
Italian Spaghetti
Buttered Green Peas
Tossed Green Salad
Cantaloupe Wedge

22
Stewed Prunes
Scrambled Eggs
•
Country Fried Steak, Gravy
Steamed Rice
Stewed Tomatoes
Pear and Cottage Cheese
Gingerbread
•
Chicken Noodle Soup
Creamed Chipped Beef on Toast
Buttered Corn
Stuffed Celery
Fruited Gelatin

23
Banana
Breakfast Ham
•
Meat Balls, Spanish Gravy
Whipped Potatoes
Brussels Sprouts
Carrot and Pineapple Salad
Apple Pie
•
Minestrone Soup
Hot Roast Beef Sandwich
Buttered Beets
Relishes
Chocolate Pudding

24
Applesauce
Soft Cooked Egg
•
Chicken Fricassee
Whipped Potatoes
Buttered Vegetables
Mixed Green Salad
Vanilla Ice Cream With Fresh Strawberries
•
Cream of Mushroom Soup
Shepherd's Pie
Buttered Asparagus
Lime Fruited Gelatin on Cantaloupe Ring
Yellow Cake With White Frosting

25
Orange Juice
Sweet Roll, Bacon
•
Swedish Meatballs
Steamed Rice
Stewed Tomatoes
Mixed Vegetable Salad With Pickle and Cheese
Cherry Pie
•
Tomato Bouillon
Roast Veal, Gravy
Green Cabbage
Potato Salad
Fresh Grapes

26
Fresh Fruit Cup
Scrambled Eggs
•
Salmon and Potato Chip Casserole
Buttered Corn on the Cob
Tomato Aspic and Cottage Cheese Salad
Cream Puff
•
Cream of Potato Soup
Baked Filet of Halibut
Buttered Spinach
Tossed Green Salad
Crushed Pineapple With Coconut and Cherry

27
Sliced Orange
Soft Cooked Egg
•
Roast Lamb, Mint Jelly
Parsley Buttered Potato
Glazed Fresh Carrots
Arabian Peach Mold
Angel Food Cake
•
Split Pea Soup
Ham Loaf, Cream Gravy
Buttered Fresh Asparagus
Grapefruit and Avocado Salad
Baked Cup Custard

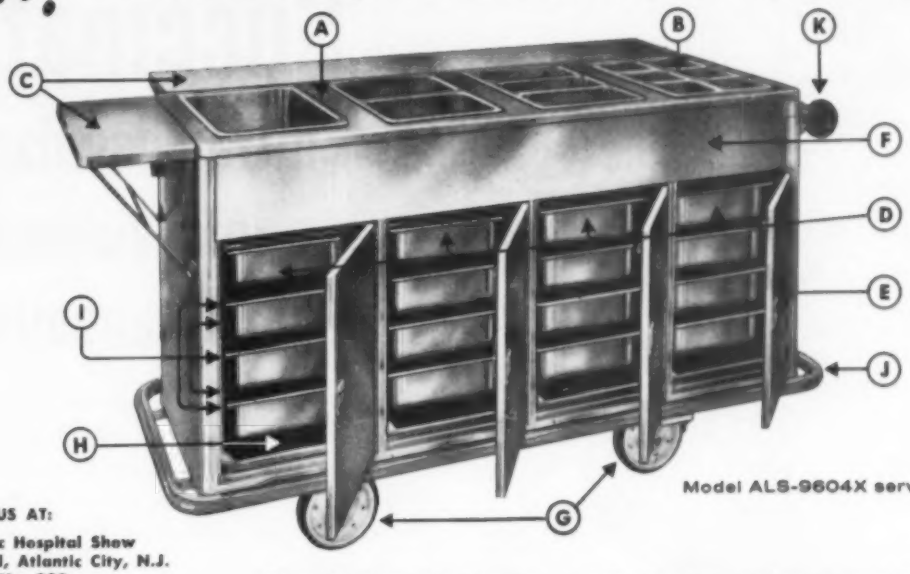
28
Banana
Hot Cakes, Sirup
•
Roast Prime Ribs of Beef
Whipped Potato, Gravy
Buttered Green Peas
Fruit Salad, Whipped Cream Dressing
English Toffee Ice Cream
•
Cream of Mushroom Soup
Cold Plate of Veal, Sliced Tomato, Chips and Relishes
Fresh Strawberries and Cream

29
Prunes With Orange
Scrambled Eggs
•
Turkey Pot Pie
Buttered Noodles
Harvard Beets
Pear Salad
Gingerbread, Whipped Cream
•
Fresh Vegetable Soup
Salisbury Steak, Gravy
Buttered Green Beans
Grated Carrot, Pineapple, and Raisin Salad
Apple Pie

30
Apricots
Breakfast Ham
•
Breaded Pork Chop
Buttered Rice
Stewed Tomatoes
Rolled Banana Salad
Fruited Gelatin, Whipped Cream
•
Cream of Green Pea Soup
Lamb Stew
Buttered Baby Limas
Stuffed Celery
Fresh Cherries

Ready-to-eat or cooked cereal served on all breakfact menus.

New! Institutional Bulk Feeder Serves up to 300 Meals per Load!



Model ALS-9604X serves 300

SEE US AT:
Middle Atlantic Hospital Show
Convention Hall, Atlantic City, N.J.
Booth No. 220
May 20-22, 1959

Model ALS-7203X serves 200

Model ALS-4802X serves 125

SEE US AT:
Catholic Hospital Show
St. Louis, Missouri:
Booths No. 309 and 310
June 1-4, 1959

Blickman-Built

Look for this symbol of quality

Check these features...each gives you important benefits!

A TOP DECK OF HEAVY GAUGE STAINLESS STEEL, one-piece *seamless construction* with all *edges rounded* and all interior corners of wells coved. Eliminates knife scraping. Smooth surfaces are easily cleaned.

B FLEXIBLE TOP DECK accepts full complement of square and rectangular, interchangeable insets, up to 6" deep*—lets you choose the top deck arrangement you need.

C DROP-TYPE STAINLESS STEEL SHELVES for convenient, easy tray assembly on large "counter" areas. Fold neatly when not in use.

D LOWER STORAGE COMPARTMENTS ELECTRICALLY HEATED and operated by toggle switch and pilot light on control panel. One compartment left unheated for greater versatility. Each compartment accepts 12" x 20" pans, up to 6" deep.

E COMPARTMENTS ARE FITTED WITH DOUBLE WALLED, INSULATED DOORS, hung on continuous piano hinges, spring actuated, with finger-tip release latches.

F TOP DECK HEATED WITH HI-FLO THERMOSTATICALLY CONTROLLED HEATERS for quicker, more uniform heating.

G FOUR STAINLESS STEEL RUBBER TIRED, BALL-BEARING EQUIPPED 8" CASTERS (2 stationary and 2 swivel-type)—provide quiet, easy maneuverability, and maximum durability.

H EXCLUSIVE BLICKMAN COVED CORNER CONSTRUCTION THROUGHOUT—provides a smooth coved interior surface for easy cleaning.

I STURDY REMOVABLE STAINLESS STEEL PAN RACKS. Racks come out easily (no tools) leaving smooth interior for quick, easy cleaning. Pan slides are set to accommodate up to 6" deep pans.*

J REPLACEABLE CONTINUOUS RUBBER BUMPER is set in heavy stainless steel channel, fully encircling the conveyor—gives greater impact protection. Will not mar walls.

K STAINLESS STEEL PUSH HANDLES mounted on stainless steel brackets, and protected by large donut type rubber bumpers—gives greater impact protection. Will not mar walls.

*Insets and pans available at extra cost.

Approved by National Sanitation Foundation

Now being used in large public institutions. Bulk feeder line consists of three standard capacities to suit your needs: 300, 200 or 125 meals. Or Blickman can build to meet specific requirements. For name and address of representative in your area and full information, write S. Blickman, Inc., 1505 Gregory Avenue, Weehawken, New Jersey.

BLICKMAN
FOOD SERVICE EQUIPMENT

INTRODUCING

Chloromycetin® Succinate

so versatile it can be given intramuscularly intravenously subcutaneously

Easily prepared for intramuscular, intravenous, or subcutaneous administration, CHLOROMYCETIN SUCCINATE can be dissolved in water or other aqueous parenteral fluids in a wide range of concentrations. Sterile solutions may be kept on hand at room temperature for 30 days without significant loss of potency.

clinical advantages—CHLOROMYCETIN SUCCINATE is relatively nonirritating by recommended routes, permitting a continuous daily dosage schedule, even to pediatric patients. It produces rapid clinical response, and is well tolerated.

CHLOROMYCETIN SUCCINATE is indicated in many serious infections responsive to CHLOROMYCETIN. Stock it now. Remember that CHLOROMYCETIN SUCCINATE may be given by all three parenteral routes.

supply—CHLOROMYCETIN SUCCINATE (chloramphenicol sodium succinate, Parke-Davis) is supplied in Steri-Vials,® each containing the equivalent of 1 Gm. chloramphenicol; packages of 10.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately, or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

PARKE, DAVIS & COMPANY
DETROIT 32, MICHIGAN

76459

Patients Deserve Good Emergency Service

Badly planned, poorly equipped, and inadequately staffed emergency rooms do a disservice both to the public, which looks to the hospital for help in emergencies, and to the hospital, which fails in its duty when this important service is neglected

James H. Spencer, M.D.

THE assumption that the emergency ward of a hospital could be a liability might seem paradoxical — yet it can be true. In order to avoid any involvement in hazy semantics let us agree that by the emergency ward we are considering that department of the hospital to which come patients needing emergency care. This is in contrast to the regular admitting office to which patients come when their hospital admission has been premeditated, and to the various clinics operating on fixed schedules. We may call it the accident room, the accident suite, the emergency room, the emergency ward, or by any other term as long as we keep in mind that it is where the public comes for medical help in a hurry. If we fail to accept the public's definition of the emergency ward, we take the first step toward making it a liability rather than an asset. Just as a physician must assume that any patient coming to his office needs medical care or at least medical attention, so must the emergency ward attendant assume that the patient who appears in this department needs prompt attention.

Ernest C. Shortliffe and his associates at the Hartford Hospital, Hartford, Conn., have stated their basic concept of a hospital emergency suite as follows: "An emergency service should offer to the public at large, and the medical community in particular, adequate facilities in which the emergencies of the area could be handled."

J. T. Howell and R. C. Buerki have stressed the public relations aspect among the many facets of emergency room care in the hospital. They state, "The emergency room could be a major source of expert diagnosis and treatment in almost any community, a vital factor in public relations since a hospital's professional reputation often rides on the fate of patient care in its emergency unit."

An Emergency Room Needs:

1. Adequate space with due regard to proximity to laboratory and x-ray facilities.

2. Provision for friends and family of the injured, police and others whose presence in treatment rooms might be detrimental.

3. Satisfactory lighting.

4. Convenient treatment tables that also serve as stretchers.

5. High quality equipment kept in this department and not shared with other departments.

6. Carefully selected and trained personnel, including doctors, nurses, orderlies and aides.

7. Most important of all, a recognition of the major importance of this department.

That many hospitals are called upon to go beyond the accepted functions of the emergency ward in the operation of this department is well known. This added patient load in the emergency ward may be the result of a difference of opinion between doctor and patient as to what constitutes an emergency. It may be an attempt on the part of the patient to by-pass the doctor in his search for medical care. This plan may be motivated by a desire of the patient to avoid the doctor's fee. In some communities this effort backfires, for the patient winds up with a hospital bill, plus the doctor's bill, when the latter might have been sufficient. Who is to say that he is not getting his just deserts?

The increased use of the emergency ward may be the result of the doctors' taking patients there for minor surgical procedures which they used to do in their offices, and, perish the thought, it has even been suggested that doctors may send patients to the emergency ward rather than to more competent fellow practitioners when they do not feel quite up to dealing

---

Dr. Spencer is chief of the staff at Newton Memorial Hospital, Newton, N. J.

This article appeared originally in *The Caduceus*, the bulletin of the Dutchess County Medical Society, Poughkeepsie, N. Y., in December 1958. The author has made some additions to the original article for publication in The Modern Hospital.

Effective system for storing emergency supplies used at one 60 bed hospital employs this wall index of the supplies, with reference to the cabinets in which they are stored. Cabinets are keyed with large numbers on their doors.

with the patient's problem. The lack of availability of doctors at night, and on week ends or holidays, has also been mentioned.

Whatever the reason for the growing use of the emergency wards for real emergencies and for medical care of a less urgent category, the problem is there and must be faced. A concerted effort to reeducate patients in the value of the family doctor would probably help to lessen the load on the emergency rooms, but no efforts along this or any other line will reduce the number of situations where an emergency ward is really needed by both patients and doctor.

References to the effect of increased mechanization and speed on our way of living have been repeated *ad nauseam*, but until the medical profession and its institutions of learning recognize this effect and prepare for it, the references must continue. The indifference toward adequate teaching of good care of the injured has been the concern of many proponents of such care for years. This was in the minds of the group of men who organized the Committee on Fractures of the American College of Surgeons many years ago, and still in their minds when they increased the scope of this committee's activities by changing the name to the Committee on Trauma.

It was this concern that moved Arnold R. Griswold to say at a meeting of the American Medical Association more than a decade ago: "The surgery of trauma is the oldest and the most important form of surgery, yet in teaching and in practice it is, even today, the most neglected form of surgery except for brief interludes during the war." He goes on to say that this is ". . . because of the neglect of the professional teachers in surgery, the teachers and the professors in our schools of medicine. The academic interests of these men have not been in the surgery of injury but in the more difficult and complicated though less common forms of surgical gymnastics." He continues, "Instead of having an interest in the surgery of injury, many professors have been more interested in determining how many pounds or feet of the abdominal contents or how much of the pulmonary tree or the brain can be removed and still have a live patient."

If it is permissible to quote myself, I will restate what I said in an address several years ago. "The departments of surgical research are combing the human body for new areas of attack. Blood trying to reach the liver by the portal vein is being shunted off in another direction, spoonsful of cerebrum are being removed from the cranium, the pancreas and adrenal glands are being roughly dealt with, and more and more nerves are being divided at their roots."

I added that I was fully aware of the importance of these procedures and granted that the time might come when I would gladly submit to one of them, but that, ". . . right now my aspirations as a prospective patient are directed more toward the hope that, if I stick my hand into a buzz saw in my basement, there will be an M.D. around who knows how to put tendons together." It was rather impudent of me to make these seeming wisecracks for it was a university surgeon who had suggested that I be invited to give the address. However, he was generous enough to tell me later that my point was well taken.

There are so many local, state and national organizations teaching and practicing good first aid, that this area of the care of the injured seems to need less critical review than some others. I believe also that a scrutiny of what takes place after the injured patient is formally admitted to the hospital and definitive care is started, or at least planned, would reveal that this phase of the care of the injured is fairly well covered in most communities. Certainly in the hospitals blessed with trained surgeons there is always someone who will thrill at the prospect of removing a ruptured spleen or fixing a fractured femur. It is in between that we find the weak link in the chain. How can we get the trained physician to take an interest in the patient who might have a ruptured spleen and accept the challenge of staying by the problem until a solution is reached? How can we be sure that a competent physician will make a thorough search for other less evident injuries than the frankly fractured femur? When we can answer these questions we shall be well on the way to assuring ourselves that the emergency ward is an asset and not a liability.

It was the desire to get the answer to these and other questions concerning emergency ward care that led a group of New Jersey surgeons to plan a critical survey of these facilities in the hospitals in that state. This program is currently the No. 1 objective of the New Jersey Regional Committee on Trauma of the American College of Surgeons. It has had the

(*Continued on Page* 120)

Do you really save money with cheap tape?

A FEW CENTS MORE BUYS Curity WET-PRUF®...

Here's how you save when you buy Curity quality!

Tears clean. No tangled, twisted, ruined adhesive. Wet-Pruf by Curity has proper body. Easy to tear, easy to handle.

Wears clean. Dressing changes are few and far between. Mainly because Wet-Pruf is water and soil resistant. It sticks, stays stuck, through heavy perspiration, washing—showers.

Stays fresh. No waste. A gentle pull and this premium adhesive unwinds clear down to the core. With Curity Wet-Pruf, the last inch is as fresh as the first.

. . . . .

When price is an immediate concern, there's Regular and extra-economy Arro®—both by Curity.

Curity . . . the other word for quality

Curity® ADHESIVE

Bauer & Black
DIVISION OF THE KENDALL COMPANY


THE TROUBLE-FREE ADHESIVE THAT TEARS CLEAN, WEARS CLEAN

(*Continued From Page* 116)

official approval of the New Jersey Hospital Association.

The surveys are made at the request of hospital administrators by teams of volunteers from other hospitals. Most of the survey teams to date have been made up entirely of surgeons, usually three in number, but in some cases an administrator from another hospital is on the team. It has been my experience in serving on several of these teams that while the purpose of these visitations is to help the hospital visited, I have never failed to learn something that I can bring back to my own hospital.

Some of the good points, as well as the weaknesses, picked up in these surveys are worth recording. Although we use a rather detailed check list on these surveys, the data collected and used for evaluation of any emergency ward may be entered under two headings: (1) physical facilities, to include space, equipment and supplies, and (2) organization and personnel.

My observations in connection with these team surveys have been augmented by visits to eight hospitals, ranging from 75 to 350 beds, in the states of Ohio and Pennsylvania. My main objective in visiting these hospitals on either side of the Ohio-Pennsylvania border was to see and learn something about emergency rooms in community hospitals.

From the standpoint of physical facilities many hospitals have suffered from the ignorance of hospital architects about such matters and the failure of medical staffs to insist on adequate and conveniently arranged space. Rooms that are too small in size and in number and poorly located with regard to entrances and exits and relationship to laboratory and x-ray facilities are glaring weaknesses often seen.

However, pleasant surprises are occasionally encountered. I recently visited a 60 bed hospital where four rooms, connected by a corridor, were available for care of accident cases. These rooms provided adequate space for seven tables or stretchers on which injured patients might be treated, and five of these were in place ready for use. One of the rooms was known as the "emergency room" and was used when only one or two patients required stretcher care at the same time. The second room was actually the "recovery room," but its location and equipment made it available for the adequate care of seriously injured patients. It has always seemed to me that the facilities of a well equipped recovery room are ideal for dealing with many of the complications of the seriously injured patient, since these complications are likely to be the same as those seen immediately following major surgery. The other two rooms in this suite were adequate in size and the lighting was superior.

However, the most impressive feature of this whole setup was the arrangement and labeling of the supplies. An extremely complete supply of equipment, drugs, plasma expanders, and so on was conveniently stored in easily opened wall cabinets with large numbers on their doors. On the wall, in fact covering an area about 8 by 10 feet, was a complete index of the supplies in large block letters with the cabinet numbers where each item was stored opposite the item (*p.* 116).

The members of the survey team were loud in their praise of the whole physical setup. Feeling that we ought to offer some constructive criticism I suggested that they change the label on the "tracheotomy" set to "tracheostomy." It was the only thing I could criticize, but of course the important thing was that the set was there ready to use not off somewhere in a central supply room with the key in a supervisor's pocket. This hospital building is quite new. The plans were drawn by a competent young architect who does not pose as a specialist in hospital planning. The medical staff is made up almost entirely of general practitioners, but someone obviously had a good conception of accident room care and got together with the architect with a good result.

Lighting is a deficiency in some emergency rooms and one that is easy to correct. Good treatment tables are also easy to get but require considerable funds. There are a number of satisfactory makes, but the best ones will cost from $400 upward. The hydraulic types will cost well over that figure. A good table for the treatment of severely injured patients should be one on which any necessary procedures can be carried out. It should be a combination operating table and wheeled stretcher. The wheels should lock. It should be easily adjustable to the shock position and should have easily attached standards to hold flasks of blood or plasma expanders so that these can go with the patient wherever he goes. It should have provision for

VITAX Connecting Tubes . . .

now at new, low prices!

Like every piece of VITAX hospital glassware, VITAX Connecting Tubes are made of extra-strength resistant glass for extra safety.

VITAX glassware will never discolor or cloud after repeated sterilization . . . withstands rough handling and corrosive action.

When it's a matter of life itself, it's in glass . . . and for the best in surgical glassware, there's nothing finer than VITAX.

#3640 Vitax Straight Connecting Tube, with constricted ends; #3680 Vitax T-shape Connecting Tubes, with constricted ends; #3690 Vitax Y-shape Connecting Tube, with constricted ends; #3670 Vitax 3-in-1 Connecting Tube, with ring connections.

Available only through your Surgical Supply Dealer

carrying oxygen, making it unnecessary to push a tank along beside the table. Stirrups for the lithotomy position are an asset in certain situations and, of course, arm boards and restraining straps are frequently needed. Removable side rails will prove valuable at times, particularly if there is a personnel shortage and a patient is irrational.

These tables should be planned with the idea that the severely injured patient will be kept on them until such time as he is transferred to an operating table or to his own bed. They should eliminate the transfers to other stretchers, x-ray tables, back to stretchers, and so forth.

The adequately equipped emergency ward will have good instruments. There is no excuse for faulty hemostats, worn-out tissue forceps, an inadequate assortment of needles, or lack of anything else that may be needed in a hurry. This is an operating room that is ready to go, not one where elective surgery is scheduled and the instruments can be picked out the night before. Anesthesia and resuscitation equipment should be there and in working condition at all times. The requisition of this equipment from the main operating rooms is definitely substandard practice. The gas tanks on these machines should be regularly checked in the daytime. There may not be time to replace empty tanks in the middle of the night. That same supervisor who has the key to central supply may have the key to the gas tank storage room. Many of these details are overlooked in good hospitals simply because no one has thought of them. They should become part of a regular routine.

Important as the physical facilities and equipment are, there is a much more important facet of good emergency ward care, the personnel. My visits to emergency rooms in other hospitals have brought out some interesting facts and in some places have plainly shown the level to which the care of the injured is relegated by those who should be most interested.

At one 75 bed hospital in Pennsylvania where there are two board certified surgeons on the staff, the administrator showed me the emergency room with justifiable pride. I then asked him about the professional coverage of this department and he explained the rotation system of the several general practitioners in the town. I asked him if the surgeons didn't share in this responsibility, too, and he replied, "Oh no, they are too busy, but of course they will come if an operation is necessary."

This phase of emergency room organization is the hardest of all to evaluate in the other fellow's hospital. It is a touchy subject and particularly so because so many hospitals have failed to realize the importance of training, experience and serious interest in this type of work. They may have clear-cut rules with regard to major and even minor surgery upstairs and a good, workable system of supervision of the younger, less experienced members of the staff, but in the emergency room the attitude may be that any doctor is all right. If it is a hospital with residents and interns, this "dirty work" may be turned over to the least experienced interns without even resident supervision. In fact the residents, who should be getting supervised training in this department, may not even have the opportunity to work there and thus may be missing an experience that might be most valuable to them when they enter private practice. If it is a hospital without in-

NOW IT'S READY...

UREVERT™

(LYOPHILIZED UREA AND TRAVERT®)

A SUPERIOR METHOD OF INTRACRANIAL DECOMPRESSION

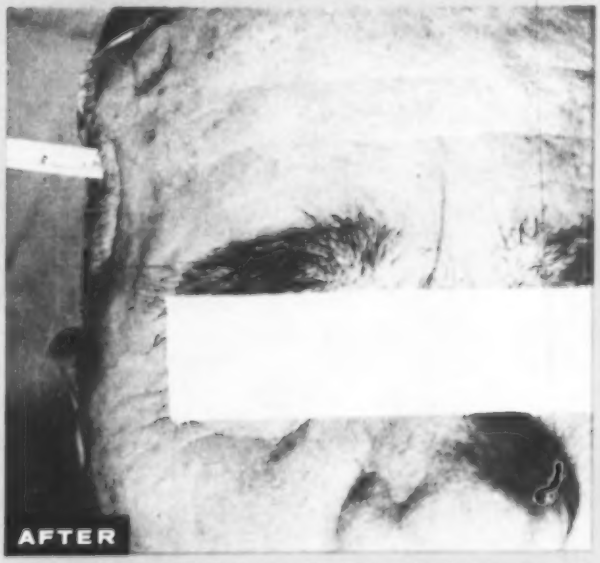
Among the numerous intracranial problems in which Urevert has been shown to be highly beneficial, reduction of a pseudomeningocele is a striking demonstration of dramatic brain decompression.

Reduction of intracranial pressure with Urevert exposes many obscure areas and often permits surgical procedures to be carried out with minimum retraction and less damage to normal brain tissue. Urevert has been described as "far superior in every respect to all other agents commonly used for this purpose."*

In depressed fractures or when intracranial pressure is acute, Urevert may be life-saving. Administered intravenously, Urevert exhibits only very occasional and relatively insignificant side effects.

*Javid, M.: Urea—New Use of an Old Agent, Reduction of Intracranial and Intraocular Pressure, The Surgical Clinics of North America, Philadelphia, W. B. Saunders Company, August, 1958, p. 22.

A pseudomeningocele following the removal of a right temporal oligodendroglioma and prior to Urevert therapy.



Bulging mass completely disappears within 2 hours after the intravenous administration of 256 cc. of Urevert.

TRAVENOL LABORATORIES, INC.

pharmaceutical products division of
BAXTER LABORATORIES, INC.
Morton Grove, Illinois

DURING INTRACRANIAL EMERGENCIES UREVERT HAS BEEN OBSERVED TO...

- Improve many prognoses
- Reduce severe headache
- Enlarge the operative field
- Minimize brain damage
- Shorten surgical intervention
- Facilitate recovery
- Shorten hospitalization

IN

- Brain tumors
- Acute glaucoma
- Cerebral edema
- CNS infections
- Head injuries
- Hypophysectomy
- Trigeminal rhizotomy

Clinically developed during the past 3 years, the intracranial decompression achieved by Urevert* permits surgical intervention and correction in many conditions where such procedures were formerly regarded as contraindicated or technically impractical. Postoperatively, its use is more expedient than ventricular puncture or drainage.

NOTE: Complete information on the indications, dosage and clinical background of Urevert is available in a Product Brochure and clinical reprints. Write to Medical Department, Travenol Laboratories, Inc., Morton Grove, Illinois.

TRAVENOL LABORATORIES, INC.

pharmaceutical products division of

BAXTER LABORATORIES, INC.

Morton Grove, Illinois

*Manufactured under license from the Wisconsin Alumni Research Foundation. Patent application pending.

terns or residents, the emergency room may be covered by indifferently trained and disinterested doctors, because those who might be more capable are too busy with what Dr. Griswold calls "the more difficult forms of surgical gymnastics."

The proper staffing of an emergency ward is one of the most difficult problems in hospital staff organization. If the hospital is large and there is a group of surgeons keenly interested in the surgery of trauma, the solution is much easier, but it must be borne in mind that the admissions are not all surgical. There are some grave medical emergencies requiring just as prompt attention and as skilled judgment as the ruptured spleen.

While I believe that owing to the high ratio of serious accidents as compared to serious medical emergencies, the responsibility for the emergency ward should be largely borne by the surgical department, a good working liaison should be established with the department of medicine. In fact, an ideal emergency ward organization will have available members of the medical staff from all departments. The variety of situations that may arise offers an excellent opportunity for the really interested general practitioner to play on the team.

The well qualified and conscientious general practitioner has my highest respect. He also has my profound sympathy if pseudo-specialists, for mercenary reasons, encroach on his field of endeavor. The general practitioner begins to lose my respect if he, for mercenary reasons, begins to become a pseudo-specialist: by this I mean, starts to invade the field of major surgery for which he is not trained. There was a time when he needed to do this, but that was yesterday. If the surgeon and the general practitioner will stick to their knitting they will gain and deserve one another's respect and neither need have any feeling of inferiority in the medical community.

I have indulged in this little excursion into medical practice philosophy in order to point out the type of general practitioner who is not only qualified to be a good emergency ward doctor, but can fill the key position. If he is keen enough he can be the quarterback and he will have the confidence and respect of the other more specialized members of the team, as well as the everlasting gratitude of the patient. It isn't a question of having an orthopedist or a general surgeon or a doctor with any other title in the emergency room, but of having a doctor who will see the whole point, put first things first, and get help if he needs it.

The selection of emergency room personnel does not stop with the roster of physicians. The team that surveyed the emergency room in my hospital reported that the nurse with whom they talked seemed well versed in the doings of that department, but pointed out that neither she nor any other nurse was regularly assigned there. We now have a regular emergency room nurse during the day shift and it is no longer necessary to call one of the floors and take potluck. Our evening and night supervisors cover those hours fairly well and don't often forget the keys. Other personnel, including nurse's aides and orderlies, need careful selection and at least a minimum of instruction for efficiency.

We have found that the hospitals that follow standardized procedures in certain emergencies seem to get the best results. This is particularly true in burns and in the treatment of shock. The effective treatment of poisoning also calls for standardization as there is seldom time for trial and error methods in these emergencies. The establishment of a "poison center" in the emergency department of the hospital will be a great boon to the physicians working in the department and to physicians who may use the center for information by telephone. The properly set up poison center not only furnishes available antidotes for most known poisons, but is prepared to give prompt and accurate information regarding antidotes in answer to physicians' telephone calls. Strategically located larger centers make available round-the-clock service in response to calls regarding less known poisoning agents.

Whether a hospital has a survey by an outside team or not, I heartily recommend to all hospitals that if they have emergency problems, they set up a carefully chosen committee representing administration, medical staff, and nursing services. If they do this, the emergency ward will be an asset and not a liability. ■

REFERENCES

[1]Shortliffe, Ernest C., Hamilton, T. Stewart, and Noroian, Edward H.: The Emergency Room and the Changing Pattern of Medical Care. New England J. Med. 258:20, 1958.

[2]Howell, J. T., and Buerki, R. C.: Emergency Unit in Modern Hospitals. Hosps. 31:37, 1957.

[3]Griswold, R. Arnold: Emergency Surgery. J.A.M.A. 135:823, 1947.

[4]Spencer, James H.: Please Call a Doctor. Bull. Am. Coll. Surgeons 39:119, 1954.

What You Don't Do Counts Most in Infection Control

By Frances Ginsberg, R. N.

Frances Ginsberg

THE problem of staphylococcal infections persists. What happens in the operating room and how the problem is approached there is no more or less important than any other place in the hospital, but somehow it requires a more exacting attention to detail for this is where the organisms find the fertile ground of the open wound.

When there are violations of sterile technics which create dangers that pave the way for infections, most, if not all of them, are errors of omission, not of commission.

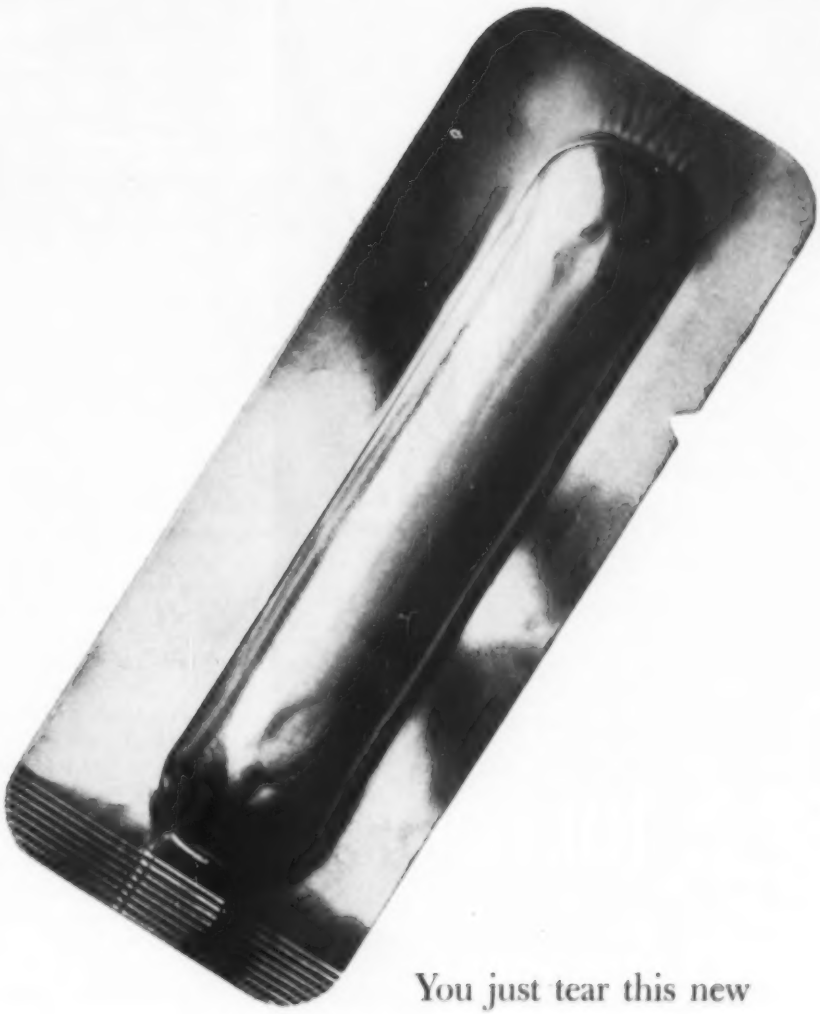
Attention to such minute details as how the air conditioning system is regulated is often disregarded only because the problems inherent in it are not understood. Simply stated, if the principle of positive pressure is maintained, that is, more clean air entering than is being withdrawn, there should be no recirculation of air or contamination of rooms by corridor air. Care and maintenance of the filters, coils and chambers of the unit should be the responsibility of the hospital engineering department working in cooperation with the air conditioner manufacturer's representative. A preventive maintenance program will pay dividends as one approach to the multiphasic problem.

Another such often overlooked consideration is the problem of traffic in and out of the operating room. Every time the door is opened and every time another person enters the room contamination increases in proportion to the number of people and amount of activity. With proper organization, the circulating nurses can remain in the room during the entire procedure. With adequate restrictions and an understanding of why, others can be prevented from "peeking" into the room during the procedure. Visitors can be limited, and those in the room can be kept to a minimum. In simple terms, the fewer the number of people in the room, the fewer the number of organisms in the environment, and the less is the chance of sepsis to the patient on the operating table.

Sometimes, the old idea of "we've always done it this way" prevents a change in a technic that could help cut down on the possibility of infections. One such problem is that of the sponge rack. It is my opinion that the sponge rack should be eliminated. Sponges drying on a rack mean the dispersion of organisms into the environment. In addition, the racks are extremely difficult to clean after being cemented with blood, serum and organic debris. Two waxed paper lined kick buckets can be used to collect, count and bundle sponges. At the end of the procedure, the liner and its contents can be disposed of. This technic meets the need and obviates a known hazard.

Another area where old ideas are a menace is that of the "indispensable person." Any member of the operating room staff with an upper respiratory infection, a skin lesion, or any other ailment in which organisms flourish, is dispensable! They constitute one of the greatest hazards to patients and other personnel. Such staff members should be returned to work only when they are completely recovered.

The only thing constant in life is change. In the operating room where life and death are in delicate balance, change may mean life in the never ending battle against infections. ■



You just tear this new
foil suture packet open
to give your surgeons stronger,
more pliable surgical gut.
It's sterilized by electron beam.

ETHICON®

Ontario Plans Aim at Solvent Hospitals

(*Continued From Page* 84)

a reasonable amount for bad debts will help reduce their losses to the point at which they cannot be of any consequence.

Much has been said by critics of the plan about an expected increase in the demand for hospital beds. The commission does not share this apprehension to any great extent because more than 70 per cent of the residents of the province already have some degree of hospital insurance, which means that most of the elective surgery will have been taken care of before this time. There will be some demand from those residents who have been unable to afford hospital insurance in the past and have been putting off needed care for financial reasons. That these persons will now have financial access to the care they require is a good thing. Given a year or two, most of this demand should disappear.

The commission recognizes that there is a shortage of chronic and convalescent beds in the province and that many acute hospitals have these types of patients in much needed active treatment beds. To relieve this situation, steps are being taken to convert unused beds in tuberculosis sanatoriums for use by long-stay patients. Also, criteria are now available whereby private nursing homes can be considered for approval as eligible to provide benefits under the insurance plan. Every effort is being made to deal with the immediate need for chronic and convalescent accommodations within the bounds of acceptable hospital and medical standards.

As to the cost of hospital care, it is not anticipated that this will rise any more rapidly than it has in the past. It is conceivable, however, that individual hospitals may be charging increased, or even decreased, rates if there have been inaccuracies in their past cost accounting.

The total effect of the work of the commission and the insurance plan will, undoubtedly, be of immense benefit to the people and hospitals of the province. The commission has one concern – the development of the best possible kind of hospital care for residents of the province and the most equitable and convenient method of paying for it. Only actual experience will tell how close Ontario is to that goal. ■

All this for one monthly fee

- ✓ Enjoy the most modern x-ray facilities . . . avoid obsolescence losses
- ✓ No surprise "extras"—covers periodic inspection, maintenance, replacement tubes, parts
- ✓ Freedom to add or replace equipment as improvements appear
- ✓ G.E. pays for insurance . . . assumes problem of collecting for equipment damage
- ✓ G.E. pays local property taxes

From This to This

without capital outlay

the difference is Maxiservice® rental

Here's the perfect answer for a cost-saving x-ray installation, easy to keep abreast of important new developments. G-E Maxiservice ties up *none* of your capital . . . eliminates trade-in losses—progress determines your time for exchange, not finances. In effect, you contract for *utility, convenience, flexibility* and *service,* not for just equipment.

For complete details, contact your G.E. X-Ray representative, or clip coupon below for your copy of our new Maxiservice booklet.

X-RAY DEPARTMENT
GENERAL ELECTRIC CO.
Milwaukee 1, Wisconsin, Room H-57

Send your new 12-page MAXISERVICE booklet to:

Name.....

Address.....

.....

Progress Is Our Most Important Product

GENERAL ELECTRIC

less nursing time, fewer

to stimulate and protect the

during corticosteroid
start . . . alternate . . .

with new, painless, intramuscular

Cortrophin®

the most prolonged, physiologic adrenocortical stimulant

(fine, aqueous suspension; flows freely through a 26-gauge hypodermic needle)

Organon

injections...no i.v. set-up

adrenal cortex

therapy: terminate

-Zinc

corticotropin-alpha-zinc-hydroxide (ORGANON)

Stimulate the adrenal cortex
Guard against cortical atrophy
Provide plasma steroid levels equal to i. v. ACTH infusion *1

Orange, N. J.

Corticosteroid therapy has been vastly improved by the newer synthetic hormones, but while side-effects have diminished, *profound depression of the adrenal cortex by these potent compounds must still be guarded against.* Therefore, whatever systemic corticosteroid is prescribed, routine intramuscular administration of CORTROPHIN-ZINC is indicated

1. *At the start*—
2. *During rest periods*—
3. *At the end* —(until cortical function is restored)[2]

CORTROPHIN-ZINC is electrolytically prepared, of unsurpassed purity, virtually free of foreign-protein reactions; need not be heated or otherwise prepared for administration, and is

1. "*. . . more potent and longer acting than gel ACTH.*"
2. "*Preferred*". . . *because it is a free-flowing substance that can be injected in a very small gauge needle.*" And
3. "*Produces a more prolonged hormone effect than other previously available repository corticotrophins.*"[3]

Peak response from the functional adrenal cortex is stimulated within two hours of the first injection of CORTROPHIN-ZINC and the ACTH effect of this unique, free-flowing intramuscular corticotropin may persist for several days.

CORTROPHIN-ZINC: 5-cc. vials, 40 or 20 U.S.P. units/cc; 1-cc. ampuls, 40 or 20 U.S.P. units with sterile disposable syringes.

1. Geller, J., *et al.*: J. Clin. Endocrinol. & Metab., *17*:390, 1957. 2. Thorn, G. W.: New Engl. J. Med., *248*:232, 1953. 3. Siegel, S. C.: Lederle Symposium Report, *1*:43, 1958.

*Except when absorption does not occur with circulatory failure.

For additional information, use postcard facing Cover 3.

Let's Give the Public the Facts About Costs

(*Continued From Page* 92)

got to try to listen to what the person has to say, and we have got to realize that the person is telling us something as well as asking us.

This is an important point that students of communication are making today: People who are bothered rarely ask the questions that are in their minds! Most often they are using the question as a technic to tell us something, to get something off their chests, or to take out anew the frustrations they may be facing with a member of the family, or with themselves, with a bad prognosis, or the frustration that comes as a result of a complaint of an entirely different nature from the circumstance they are asking about. In other words, they may be upset by something someone else has done, but we are the only ones they can get to listen, so they use this as a means of complaining about one thing while getting the other complaint off their chests! This is what we call grievance drainage. As we listen, we shouldn't think the other person is either stupid or is trying to be nasty to us as individuals. Many times they have got to be nasty to somebody, because they need the satisfaction of telling someone off. They may not know who is really responsible or they may not want to antagonize that person.

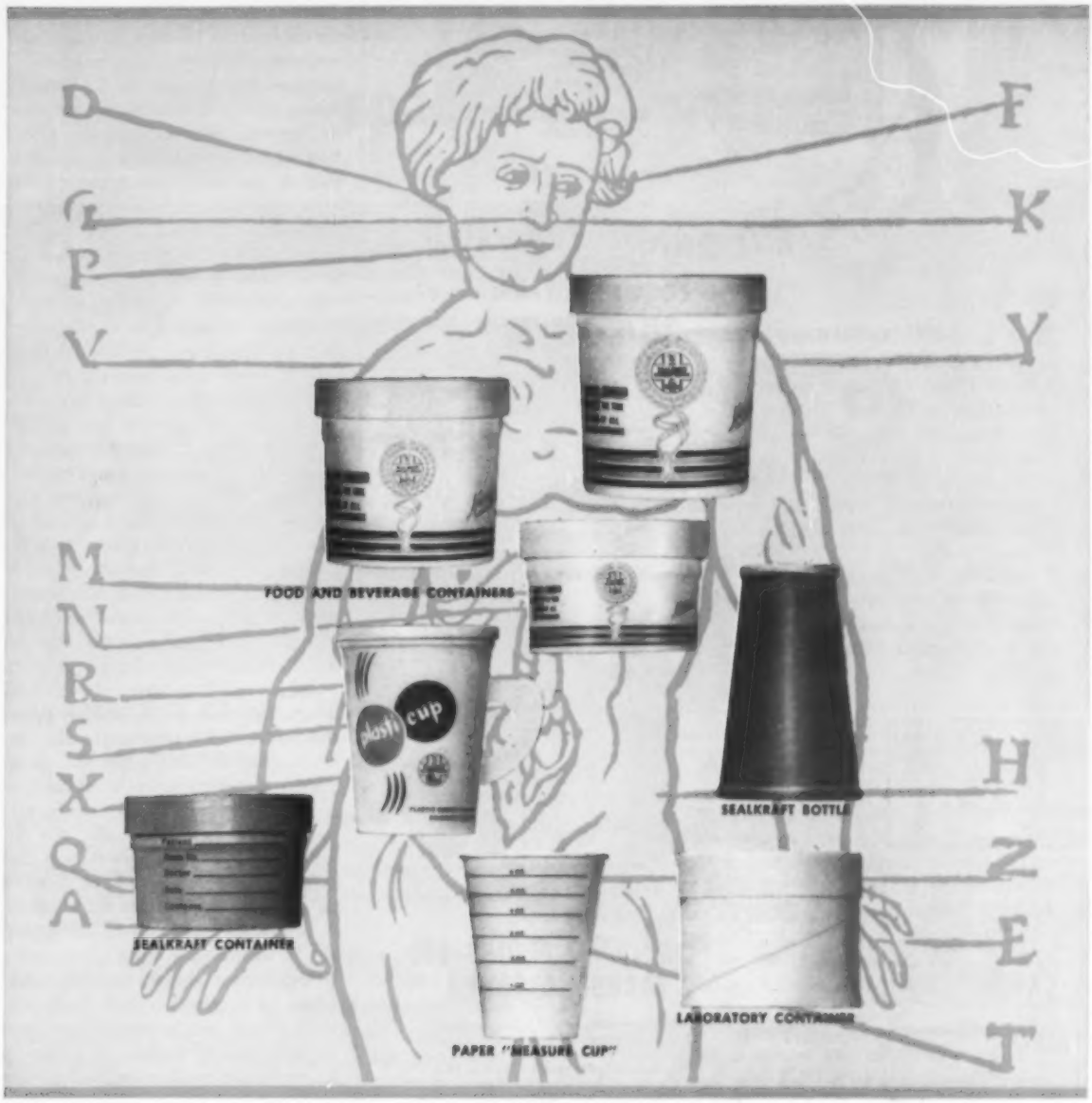
Another point on the matter of communication is that the other person often won't hear what we say because in some cases he isn't interested in the answer to start with, and in other cases he knows what we are going to reply, or he thinks he does anyway, so what he hears is what he thinks we are going to say rather than what we do say.

This means that we can't go into any long discussions on hospital costs. We have got to be specific. We have to make sense to a person who has the same difficulties in listening to our replies that we have had listening to the question he was asking!

To be effective, we have to feel secure about what we are saying; we must know the basic answers to the questions about hospital costs. If I am going to give what will be taken as believable answers, then I must speak from a sense of security, I must feel that I know more than the questioner does about the questions asked me, and I must feel that in general I know nearly all there is to know about it. For this reason everyone in the hospital has a responsibility to ask questions of other people in the organization who may be in a good position to know the answers. When patients and relatives ask questions that the employe doesn't feel secure in answering, then I think the employe should refer the individual to the people who can give him the sort of information that will represent sensible, accurate and definite answers. The person who does give the answer to the patient should always inform the employe of the answer that was provided to the patient.

If we expect the public to understand hospital costs we must first understand them ourselves. The responsibility for such understanding begins with the administration which has access to all the information. This responsibility must be carried out, however, through those members of the organization who have contact with the patient and his relatives. This means that all of us within the hospital must have inside information and be willing to share it and interpret it to those on the outside. ■

proven HOSPITAL-RIGHT wherever used



Already the "First Choice" of hospital technicians, nursing and kitchen personnel everywhere. Sealright, **Hospital-Right,** all-purpose disposable paper containers are **so right** too, for your hospital's every single service container need.

Try a **Test** supply . . . . . experience a new efficiency . . . . . added service effectiveness, and enjoy new immense savings as well.

Sealright

SEALRIGHT-OSWEGO FALLS CORPORATION
Fulton, New York Kansas City, Kansas
Sealright Pacific Ltd., Los Angeles, California
Canadian Sealright, Peterborough, Ontario, Canada

CREATORS OF **HOSPITAL-RIGHT** SINGLE SERVICE ALL PURPOSE CONTAINERS

SEALRIGHT CO., INC., FULTON, N. Y. MH-5-59

Send me a sample kit of "Hospital-Right" Sealright's disposable containers.

My name ..... Position .....

Hospital name .....

Address .....

City ..... Zone ..... State .....

A Conference Is As Good As Its Leader

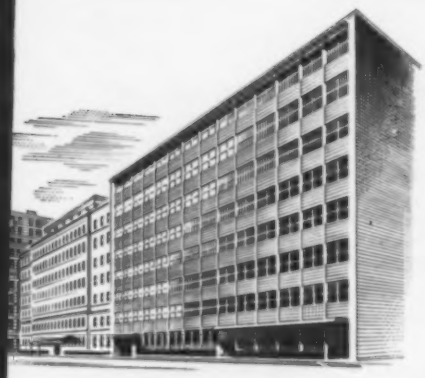
(*Continued From Page* 102)

at by the group. A report of the general discussion is not necessary for most of the conferences we are discussing. The conference leader can also make excellent use of a recorder by occasionally asking him to state what he sees to be the general agreement of the group that might be committed to paper. If time is available during the conference, a recorder might make occasional summaries or one summary at the end indicating what he is going to include in his notes. If time does not permit, then a copy of the recorder's notes should be circulated to all the members participating in the conference as well as to other interested parties. It should be specifically stated that these are the recorder's notes and not the official minutes of the conference.

Sometimes, it is well to designate also one person as the *observer*. This person can possibly be described as the conscience of the group. It is his function to look at how the group is working rather than what it is accomplishing. He can be useful when the group appears to have bogged down in a discussion of personalities or is off on a tangent which appears to be splitting it into too many parts. At that point, the conference leader might ask him to indicate at what point the group appeared to get lost and what kinds of conference behavior appear to be getting in the way. Obviously, the observer would usually have to be a person with some training and be sensitive to group behavior. If such a person is available, his value to the group can be enormous.

Supervisors who are sincerely interested in developing their leadership skills should not become discouraged by early lack of success. In becoming a competent conference leader, time and patience are essential. A good coach or training program is also helpful. If conferences are used frequently in a hospital, the administrator might consider bringing in an outside specialist to work with the supervisors on just conference leadership. The cost of this will be more than returned to the hospital in the form of increasingly productive conferences.

Beginning with the next article, the training will move into a different area of concern to supervisors. The next few articles will deal with bringing the new employe onto the job, training him, and working on job improvement. ■



How Mt. Sinai Hospital gains nursing time, cuts foot travel, speeds all services!

AUDIO-VISUAL NURSE CALL SYSTEM. At Mt. Sinai, Executone's two-way voice communication between patient and nurse cuts nurse's foot travel more than 60%...allows nurse more time for actual patient care.

New York's famed Mt. Sinai Hospital has pioneered in the application of electronic voice communication. Starting 14 years ago with its first Executone Intercom System in the Radiology Department, Mt. Sinai quickly extended the use of this modern time-saving equipment.

Today, Executone is an integral part of Mt. Sinai, serving the entire hospital. With 325 beds already served by Executone's Audio-Visual Nurse Call System, Mt. Sinai has applied other Executone intercom and sound systems to its many services and departments. Thousands of needless steps are saved daily at Mt. Sinai with Executone—clear, distinct two-way conversations take place at the touch of a button. The over-all result is more personalized patient care and improved administrative efficiency.

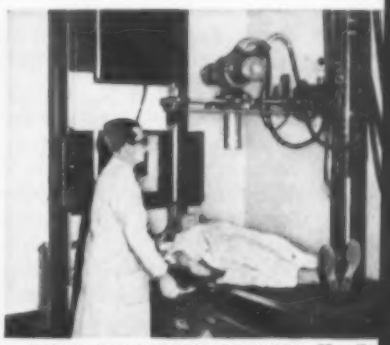
Hospitals throughout the nation have discovered the effectiveness, economy and complete dependability of Executone for *all* services. Executone's Audio-Visual Nurse Call System alone is now serving over 12,000 hospital beds. Find out—*without any obligation*—how Executone can work for you as it does for Mt. Sinai and the entire hospital field. Write to Dept. Z-8 for further information: Executone, Inc., 415 Lexington Avenue, New York 17, N. Y. (In Canada—331 Bartlett Avenue, Toronto.)

Executone

HOSPITAL COMMUNICATION SYSTEMS

NON-CORRIDOR PAGING. Doctors' paging calls at Mt. Sinai are reproduced at Nurses' Stations—not in Patient Corridors. (Arrow indicates paging unit.)

CENTRAL KITCHEN COORDINATION. An average of 6600 meals are served daily. Executone speeds activities with communication between Steward, Dietician, Food Preparation and Serving areas.



RADIOLOGY TRAFFIC CONTROL. Handlin of patients coordinated through Executo between technicians, Reception area, Da room, Film Files, and Chief Radiologist.

NEWS DIGEST

Hospital-Blue Cross Honeymoon Is Over, A.H.A. President-Elect Says . . . National Hospital Week To Emphasize "More Roads to Recovery" . . . Union Sets Deadline In New York Hospital Labor Dispute . . . Roundup of Spring Conventions

Hospital-Blue Cross Honeymoon Is Over, A.H.A. President-Elect Tells Conference

ATLANTA. — The hospital-Blue Cross honeymoon is over, but divorce is unthinkable, a national hospital leader told the 22d annual assembly of the Southeastern Hospital Conference here last month.

Hospitals and Blue Cross plans will and should be critical of each other in a constructive way, but they must continue to live together, Dr. Russell A. Nelson, director of the Johns Hopkins Hospital, Baltimore, and president-elect of the American Hospital Association, told the conference.

Gene Kidd, administrator of the Baptist Hospital, Nashville, Tenn., was named president-elect of the conference at the annual business meeting. He will succeed Oscar S. Hilliard, administrator of the John L. Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe, Ga., who became president during the conference. Robert A. Ivy, Doster Hospital, Columbus, Miss., was the retiring president.

Registration at the conference exceeded 2300, a record attendance, Charles W. Flynn, executive secretary, reported.

In its relationship with hospitals, Blue Cross must avoid becoming a "bargain-seeking negotiator," even though it has the financial power to take such a position, Dr. Nelson warned. Instead, he suggested, Blue Cross should use its financial resources to help hospitals expand and improve their educational programs.

"Blue Cross has a big stake in the future of hospitals and must recognize its responsibility for the future," he said.

If Blue Cross plans are forced by legislatures or state insurance officials into neglecting their responsibility for the financial future of hospitals, the entire voluntary hospital system may be undermined, Dr. Nelson told the group. He urged tighter self-control by Blue Cross plans and hospitals as the only way to forestall more and more governmental interference with hospitals.

"Hospitals and their staff physicians must cooperate to guarantee high standards of patient care and self-restraint in the use of hospital facilities," he concluded.

Another speaker at the conference, James E. Stuart, executive vice president of the Blue Cross Association, New York City, agreed with Dr. Nelson that hospitals and Blue Cross are facing a crisis that may threaten the future of the voluntary hospital and health care system. Elements of the crisis, as listed by Mr. Stuart, included:

New officers of the Southeastern Hospital Conference are, left to right: Gene Kidd, president-elect, Oscar S. Hilliard, president, and Glenn M. Hogan, the executive secretary.

1. Health care has come to be considered the right of all people, regardless of age, economic situation, or state of health.

2. Health care costs must continue to rise, as will utilization of hospital facilities.

3. Public education in the nature of hospital and health care problems and operations has been inadequate.

4. Prepayment programs must be extended to meet the needs of all people and fit the requirements of all hospitals.

5. Service benefits available through prepayment must be continuous, with-

(*Continued on Page* 166)

National Hospital Week To Emphasize Theme, More Roads to Recovery

CHICAGO. — "More Roads to Recovery," the theme of National Hospital Week, May 10 through 16, emphasizes that the smallest hospital today can offer services that were unknown in even the great medical centers yesterday.

The American Hospital Association, sponsors of the week's observance, points out that not only have these new services been developed, but that "the great medical centers today are developing the routine hospital services of tomorrow."

Several examples are furnished by the association:

"In 1946 only 53 per cent of the 4400 short-term hospitals had electrocardiographs. By 1957 there were 5300 hospitals and 92 per cent had this tool.

"The first hospital blood bank was not established until 1937, but by 1946 there were 1100 hospitals with blood banks and nearly 3200 by 1957.

"Radioactive isotopes were already in use for diagnosis and treatment in nearly 300 hospitals in 1952; by 1957 nearly 900 hospitals had radioactive isotope departments.

"Recovery rooms . . . have now been established in nearly 2000 hospitals compared with only 500 in 1951. The number of hospitals with premature nurseries rose from 1600 in 1953 to 2500 in only four years."

This expansion of complex services, the statement said, accounts for a large part of increased hospital costs.

General services such as housekeeping, laundry and plant operation and maintenance are not responsible for the jump in hospital costs, the association asserts. The big increase is in the cost of nursing and the special service departments, such as laboratory, x-ray, operating room, and medical records.

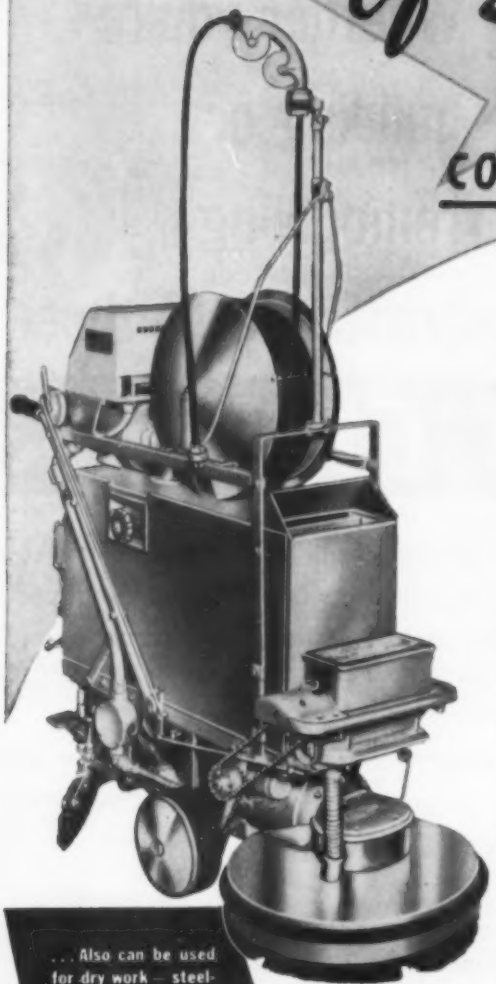
"The areas which directly provide the new roads to recovery represent the real increase in hospital costs," the association statement concluded.

SMALL-AREA BUILDINGS...

Save 2/3 of Every Hour of Scrubbing Time

WITH A

COMBINATION SCRUBBER-VAC!



... Also can be used for dry work — steel-wooling, et cetera

(Powder Dispenser is an accessory)

Today, even buildings with but 2,000 to 15,000 sq. ft. of floor space can reap the labor-saving, cost-reducing benefits of *combination-machine-scrubbing*. Here's a *Combination Scrubber-Vac, Finnell's 418P* at left, that's specially designed for such buildings. This *electric* unit, with its 18-inch brush spread, cleans floors in *approximately one-third the time* required with a conventional 18-inch machine and separate vac.

The *418P* applies the cleanser, scrubs, and picks up (damp-dries the floor)—*all in one operation!* Maintenance men like the convenience of working with this single unit... the thoroughness with which it cleans... and the features that make the machine simple to operate. It's *self-propelled*, and has a *positive* clutch. There are no switches to set for *fast* or *slow*—slight pressure of the hand on clutch lever adjusts speed to desired rate. The powerful vac performs quietly. Compactly built, the *418P* also serves advantageously in larger buildings for the care of floors in narrow aisles and congested areas, and is available on lease or purchase plan.

Finnell makes *Scrubber-Vac Machines* for small, vast, and intermediate operations, and in *gasoline* or *propane powered* as well as *electric* models. From this complete line, you can choose the size and model that's exactly right for *your* job (no need to *over-buy* or *under-buy*). It's also good to know that *a Finnell Floor Specialist and Engineer is nearby* to help train your maintenance operators in the proper use of the machine and to make periodic check-ups. For demonstration, consultation, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1405 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

FINNELL SYSTEM, INC.

Originators of Power Scrubbing and Polishing Machines

Everything FINNELL for Floor Care

BRANCHES IN ALL PRINCIPAL CITIES

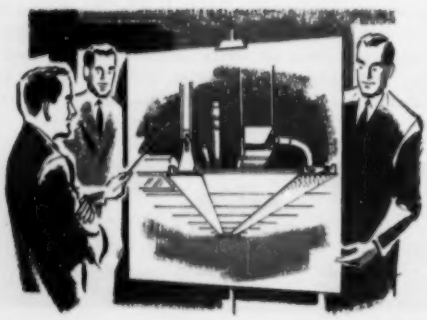
Whether you're building or remodeling

be sure you get the advantages of these

ACOUSTI-CELOTEX

"Hospital Quiet" is as important in your planning as "Hospital Clean" . . . is essential to staff efficiency and patient comfort. But you can expect more than just Quiet from a wise ceiling investment. It costs no more to get the vital plus benefits that are part of every installation of Acousti-Celotex Sound Conditioning.

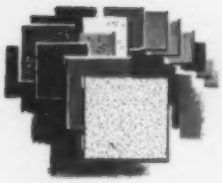
Good today is not enough. Good tomorrow must be assured. For permanent satisfaction, it pays to remember that only Acousti-Celotex can give you all these "Quality Plusses"!



Ceiling Consultation Service

Expert advice on new ways of putting ceilings to work is yours without obligation through your Acousti-Celotex distributor's ceiling consultation service. For example, he will show you how you can economically combine lighting, air-conditioning, sound-conditioning and concealment of utility lines, all in one project . . . how you can have easy maintenance, and complete repaintability without sacrificing permanent acoustical efficiency.

Write today for free booklet "The Quiet Hospital" and name of your nearest Acousti-Celotex Distributor.

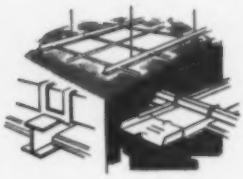


1. PRODUCT LEADERSHIP

More products to choose from, the newest in designs, and manufacturing quality backed by 34 years of job-proved performance.

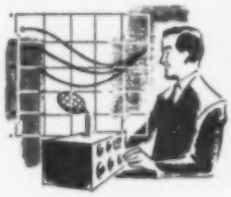
2. FRANCHISED DISTRIBUTORS

Your Acousti-Celotex Distributor is a member of the world's largest acoustical organization . . . your assurance of engineering skill, dependable service.



3. INSTALLATION VERSATILITY

With the widest variety of installation methods as well as products, your Acousti-Celotex Distributor can more effectively meet the design needs of every job.



4. SOUND CONDITIONING ANALYSIS

Expert recommendations on materials and installation needed to reduce noise levels; prevent noise spread; improve hearing conditions.

5. TRAINED PERSONNEL

Distributor representatives are thoroughly trained by Celotex engineers . . . continually kept up-to-date on latest developments in acoustics and construction.

6. JOB CRAFTSMANSHIP

"The best crews on the scaffold," proud of their fine reputation, working with the products they know so well . . . Acousti-Celotex materials.

QUALITY "PLUSSES"

7. CEILING ENGINEERING

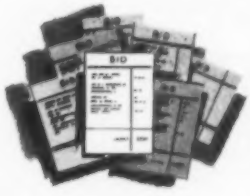
The best in construction planning assistance, from the organization that installs more ceilings of all types than any other in the world.

8. ADVANCE INSPECTION

Pre-checking of all job conditions insures proper permanent installation and guards against future troubles.

9. JOB SUPERVISION

Progress of every job repeatedly checked by your distributor's experienced job supervisors – insuring that high Acousti-Celotex standards are maintained.



10. COMPETITIVE PRICES

You get all these quality plusses without paying more . . . greater value in products, engineering skill and job dependability, without extra cost!

ACOUSTI-CELOTEX SOUND CONDITIONING

TRADE MARK REGISTERED U. S. PAT. OFF.

Products to meet every problem...every building code

The Celotex Corporation, 120 S. La Salle Street, Chicago 3, Illinois • In Canada: Dominion Sound Equipments, Ltd., Montreal, Quebec

New York Union Sets Strike Deadline; Locals Picket in Hospital Labor Dispute

NEW YORK. — Threat of strikes faced six voluntary hospitals here when Local 1199 of the Retail Drug Employes Union announced an April 22 deadline for hospitals to recognize the union as bargaining representative for nonprofessional employes. (See story on Page 56).

Announcement of the deadline was one of three new major developments in the hospital labor dispute. Other developments were:

1. Local 302 of the State, County and Municipal Employes joined forces with City Employes Local 237 of the International Brotherhood of Teamsters in an effort to remove Local 1199 from the hospital field.

2. The teamsters and municipal employes unions picketed two hospitals, tying up trucks delivering hospital supplies.

The six hospitals affected by the strike deadline are Mount Sinai, Jewish Hospital of Brooklyn, Bronx Hospital, Beth David, Beth Israel, and Lenox Hill Hospital. Leon J. Davis, president of Local 1199, announced that a majority of the nonprofessional workers at each of these hospitals had voted to have the union bargain for them.

In addition, Mr. Davis said, the union has majorities at Knickerbocker, Flower Fifth Avenue, Beth El, Polyclinic, University, and Long Island Jewish hospitals.

It was under a similar strike threat that Local 1199 succeeded in gaining recognition and a contract in February at Montefiore Hospital in the Bronx.

The employes organized by the drug employes union include dietary, housekeeping and laundry workers, nurse's aides, laboratory and x-ray technicians, registered pharmacists, and maintenance workers.

Locals 237 and 302, the two new entries in the voluntary hospital dispute, have been in a six-year feud in their efforts to sign up city employes. Each claims several thousand members among municipal hospital employes.

Deliveries of oxygen tanks and other vital supplies were interrupted at Presbyterian Hospital in March when 13 drivers encountered pickets. The picketing was primarily a demonstration by Local 302 of the state, county and municipal employes, who were joined by the teamsters.

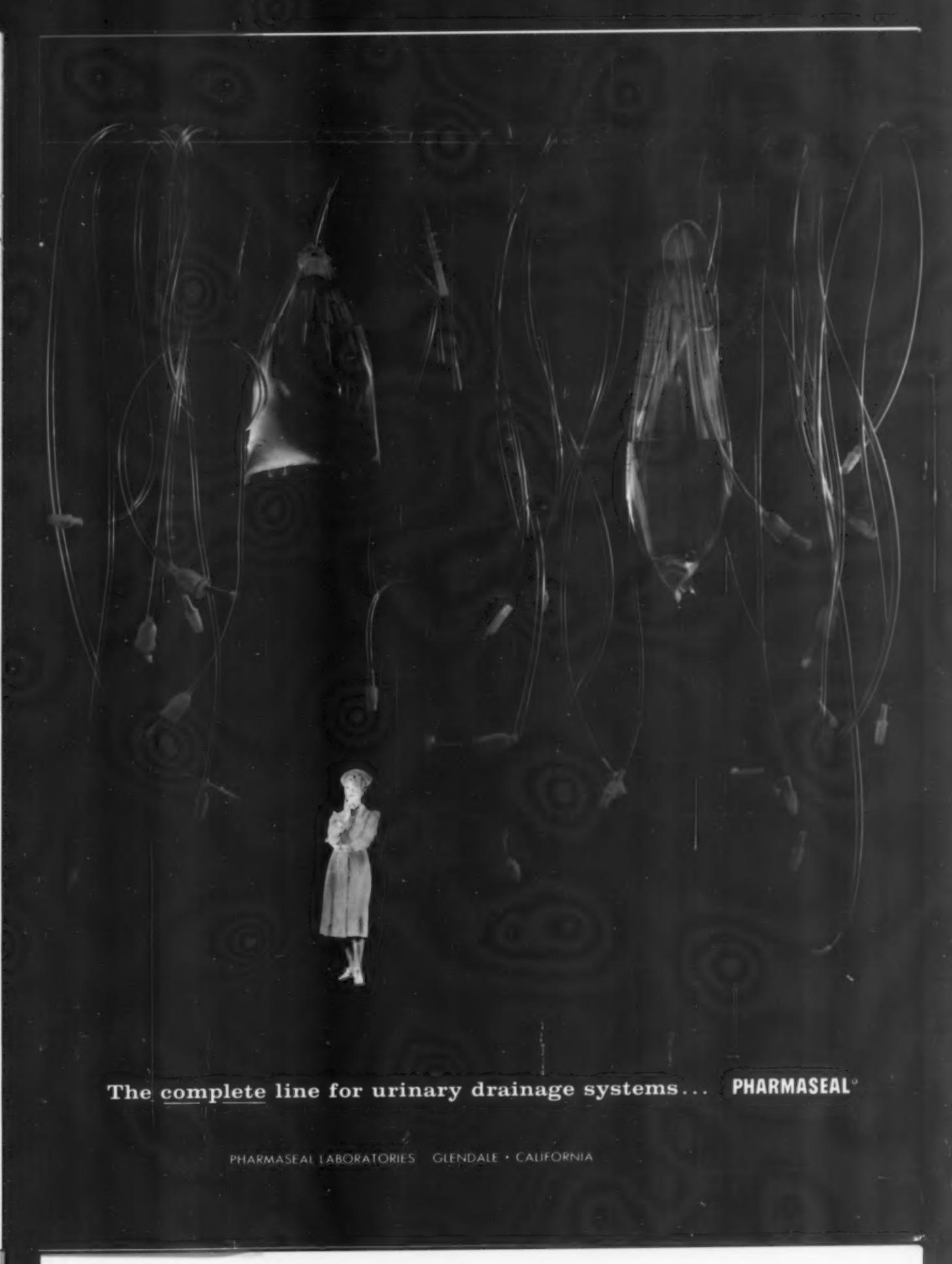
A week later the teamsters union organized picket lines at New York Hospital. Dr. Henry N. Pratt, director of the hospital, said 50 trucks arrived at the hospital's entrances, but most of the drivers ignored the pickets. Drivers of 10 trucks refused to make deliveries.

Henry Feinstein, president of the teamsters local, had announced in advance that while the delivery of oxygen tanks would be assured, the hospital would "have to take its chances" on other deliveries.

Mr. Feinstein met with Dr. Pratt in an eight-minute conference 45 minutes before the picketing ended. It was the first contact between the union leader and the hospital official.

Dr. Pratt turned down Mr. Feinstein's request to talk about hospital employes or to turn the question of union recognition over to the city labor department. He told the teamster official that he did not believe it was

(*Continued on Page* 143)


The complete line for urinary drainage systems... PHARMASEAL®
PHARMASEAL LABORATORIES GLENDALE • CALIFORNIA

"legally or morally right to have unions in nonprofit, charitable hospitals."

Before the meeting he had expressed strong doubt of a union claim to represent a majority of the hospital's 2700 employes. The picketing was carried on by members of the teamsters local who were not hospital employes.

Commenting on efforts to head off the scheduled walkouts at six voluntary hospitals, the New York *World Telegram* said:

"All the strike threats in creation can't alter the economics of the situation. But they can, and do, pose a grave threat to the lives and welfare of hospital patients. The threat is more than grave—it's unthinkable and intolerable! A full-scale strike, particularly one accompanied by disruption of deliveries, could be literally a life-or-death crisis."

Meanwhile, the *Wall Street Journal* reported, there was evidence that the movement to organize nonprofessional hospital employes is spreading across the country. The teamsters union has already begun a drive to organize nontechnical employes of county hospitals in Miami. James Hoffa, president of the teamsters, said he had turned down repeated requests to organize Detroit's hospitals because the climate of public opinion is not ready yet, the *Journal* reported.

Arnold S. Zander, president of the American Federation of State, County and Municipal Employes, was quoted as saying his eventual goal is to sign up some 500,000 hospital workers in tax supported hospitals, but he denied a campaign directed at voluntary hospitals.

Examination Scheduled for Foreign Trained Physicians

CHICAGO. — More than a thousand foreign trained physicians have already registered for the next qualifying examination of the Educational Council for Foreign Medical Graduates to be given September 22, according to Dr. Dean F. Smiley, executive director of the council.

Already 2914 physicians have taken the three previous examinations to establish their qualification to assume internships or residencies in U.S. hospitals. Approximately 48 per cent of them won standard certificates and more than 26 per cent more were given temporary certificates.

Internship Offered in Hospital Housekeeping

OAKLAND, CALIF. — An internship for housekeepers is being offered by Alameda County Medical Institutions, Oakland, Calif., beginning July 1 for a one-year period.

The intern will receive training at an executive level in three county hospitals and three private hospitals. The training will consist of formalized sessions on personnel relations, job training, interior decorating, purchasing, scheduling, supplies and equipment, interdepartment relations, and safety. The intern will spend time in stores, purchasing department, and in the laundry to observe, according to Mildred F. O'Donnell, director of housekeeping services, Fairmont Hospital, San Leandro, Calif. In addition, the training will consist of teaching the intern all the methods involved in good hospital housekeeping, Mrs. O'Donnell said.

Applicants should be between the ages of 25 and 35 and should have two years of college in home economics, teaching, business or nursing, the sponsoring institutions announced.

Don't Overlook Trustees As Aids in Problem Solving, "Carolinas-Virginias" Told

ROANOKE, VA. — Hospitals may be guilty of overlooking an important group capable of helping them solve their problems, Dr. Edwin L. Crosby, director of the American Hospital Association, said in a speech delivered here last month at the 29th annual meeting of the Carolinas-Virginias Hospital Conference.

The 60,000 hospital trustees in the United States, said Dr. Crosby, must assume responsibility for highest grade hospital service and help explain costs to the public. "One of our biggest mistakes," he said, "has been in not involving our hospital trustees in our problems."

One of these problems, perhaps the biggest, — a nursing shortage that seems to be expanding instead of shrinking — was examined by Dr. Russell A. Nelson, A.H.A. president-elect, in another session. Dr. Nelson, director of Johns Hopkins Hospital, Baltimore, said that 10 per cent of all budgeted nursing positions in hospitals today are vacant. He characterized this shortage of nursing personnel as "the most serious problem in patient care in hospitals today."

In view of the importance of nursing service to hospitals, said Dr. Nelson, "it is incredible that until last year the A.H.A. had a very limited nursing program." He called for joint effort by nurses, hospitals and physicians to "study, improve and carry on the nursing education accreditation program."

Dr. Nelson said that three factors have given rise to the demand for a joint accrediting service for nursing schools: (1) rising costs of nursing school accreditation service, (2) inflexibility of field inspection service, and (3) vagueness of accreditation standards.

Another area of concern to hospitals and nurses discussed by Dr. Nelson involved collective bargaining, "a practice of unions," said Dr. Nelson, "that has no place in nursing." More is needed here, he suggested, than passive resistance.

"The way to combat collective bargaining," he said, "is not to just oppose it but to eliminate the evils which have led to the demand by nurses for collective bargaining."

In a ceremony held during the conference, Dr. Nelson presented the grand safety award of the National Safety Council to William Flannagan, administrator of Roanoke Memorial Hospital, Roanoke, Va., who accepted it on behalf of the hospital.

The opening session of the two-day meeting, April 16 and 17, featured an address by the governor of West Virginia, Cecil H. Underwood, who said that some governmental involvement in medical care is inevitable. Government, he said, should step up its activities in the medical field but not to the point of cutting out private enterprise.

"I am confident," said Gov. Underwood, "that both private medical enterprise and complementary government efforts will face the challenge and act within the framework of our well recognized economic system."

Hospital administrators — and others — may have gone overboard in meeting the psychological needs of employes, J. Mitchell Graybard said at the final general session of the conference. Mr. Graybard, director of personnel, Smith, Barney and Co., New York City, said this attitude marks the end of an era in personnel relations.

"The time has come," he said, "to

stop coddling and start firing and tell people in plain English why they were fired."

Too often, said Mr. Graybard, steady, reliable workers are taken for granted and too much time is spent instead on coddling the 5 per cent of the working force who are "problem children." This time, he suggested, could be more profitably spent in working with the steady workers who are the background of your organization and in showing appreciation for their performance.

V.A. Announces New Infection Control Plan

WASHINGTON, D.C. — A strict program of preventive measures against hospital infections, including those from drug-resistant staphylococcus, was announced by the Veterans Administration last month.

Dr. Irvin J. Cohen, V.A. assistant chief medical director for planning in Washington, D.C., said the new program is a precautionary move based largely on recent findings of a six-hospital V.A. study that has been under way for about 18 months to prevent hospital infections. He emphasized that there has been no serious outbreak of infection in V.A. hospitals.

The research study indicates an unexpected prevalence of the drug-resistant microbes among V.A. patients at the time of hospital admission, increasing the likelihood that several strains of staphylococcus are dangerous as potential causes of drug-resistant infection, Dr. Cohen said.

He said the new V.A. preventive program will be carried out jointly by the agency's hospitals and by V.A. area infectious disease reference laboratories, with coordination by the area medical offices and the central office.

Each V.A. hospital will establish its own infection committee with representation from all major hospital departments, including administrative, all clinical services, nursing, housekeeping and laboratory.

The committees will develop and monitor standards of "scrub and sterilize" cleanliness for the entire hospital and will make frequent checks to spot any rise in infection before an outbreak can occur, Dr. Cohen said.

The area reference laboratories will help the hospital committees by identifying organisms and testing them for drug resistance.

Inter-Hospital Cooperation Urged As Means of Avoiding Socialized Medicine and Hospitals

KANSAS CITY, MO. — Expansion of voluntary prepayment, greater efficiency in hospital and medical care and increasing inter-hospital cooperation offer the only hope for avoiding socialization of hospitals and medicine in the United States, Hal G. Perrin, administrator of Bishop Clarkson Memorial Hospital, Omaha, said here last month at the opening general session of the Mid-West Hospital Association's 31st annual meeting.

Resentment about increasing costs of health care has been caused by the failure of health care administrators to enlighten the public, Mr. Perrin said. As a result, "the threat of government medicine gives hospital people, doctors and insurance companies the shakes."

More than 2000 hospital administrators, auxiliary members, trustees and others registered for the convention, Margaret Barber, executive secretary, reported. C. E. Copeland, administrator of the Missouri Baptist Hospital, St. Louis, was named president-elect of the association during the meeting. He will succeed Herbert A. Anderson, administrator of Lincoln General Hospital, Lincoln, Neb., who became president.

James G. Carr Jr., administrator, Memorial Hospital of Natrona County, Casper, Wyo., was the retiring president.

To ensure efficient hospital facilities and services and avoid expensive duplication, Mr. Perrin suggested, all fund raising and hospital construction in the future may be carried out following approval by local, area and regional hospital planning councils.

In the future, he predicted, hospital educational costs now borne in large part by patients will be transferred to students. "Especially, I think tuition rates in most hospital schools of nursing are unnecessarily and unfairly low," he said. "It is forecast that the $500 to $1000 rates now commonly in effect will soon be $1500 to $2500 for a three-year course and that recruitment will not be adversely affected by this increase."

Another glimpse of the hospital future was presented by Tol Terrell, administrator of the Shannon West Texas Memorial Hospital, San Angelo, Tex., and immediate past president of the American Hospital Association, who predicted that per diem costs may rise to $45 within the next 10 or 15 years.

Mr. Terrell also predicted that in the future hospital patients will be "monitored" by television, physicians' offices will be based at hospitals, business procedures will be conducted largely by electronic computors, and outpatient departments will be substantially expanded.

Nevertheless, Mr. Terrell warned against overexpansion of hospital beds and facilities. "There is no need to increase the number of beds per 1000 population," he said.

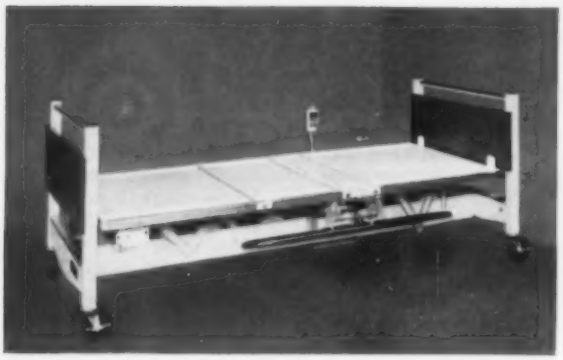
Hospitals will compete for qualified personnel, but they should cooperate in planning facilities and services for their communities, Mr. Terrell agreed. "Only by such cooperative planning can a comprehensive program of health care be accomplished with the least possible cost," he said. "How many times we have services just to keep abreast of our neighboring hospitals. Our planning objective is com-

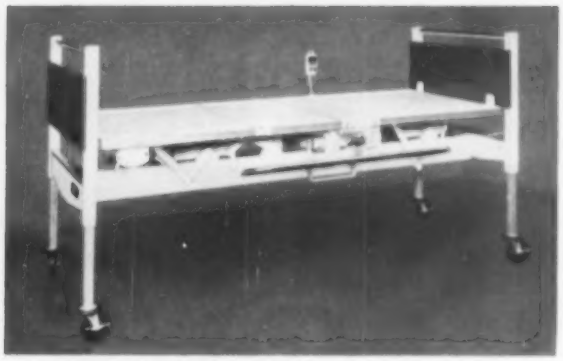
(*Continued on Page* 152)

AMP

ALL-ELECTRIC HOSPITAL BED

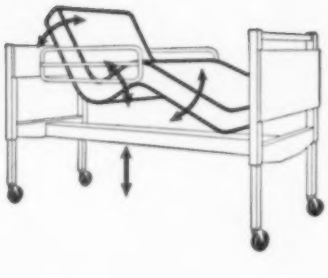
is longer...lowers lower...and raises higher than any other electric bed on the market





Three-piece posture-firm mattress panels, 7 feet in length, can accommodate an 84-inch mattress. Panel height of bed can be adjusted from 16½ inches to 30 inches, or a mattress height of 21 inches to 34½ inches. Low mattress height assists patient's early ambulation, and high mattress height makes it convenient for nursing personnel to attend to patient's needs, or make beds, without stooping or bending.

and the AMP All-Electric Bed is the ONLY bed that offers all these features



1—Hand-held, push-button switch is instantly accessible for patient or nurse.

2—Eight distinct motorizing actions . . every desired position of bed is electrically operated, smoothly, quietly.

3—AMP bed is the only bed that can achieve all the approved medical positions electrically.

4—Head, seat and foot sections are electrically, individually activated by patient or nurse merely by pushing a button.

5—Three-piece posture-firm mattress panels eliminate need for bed boards. Easy-to-clean panels assure a truly clean mattress surface.

6—AMP bed is the only bed that has self-storing, hide-away side rails. Construction of bed permits quick, easy storage of rails under mattress panels.

7—AMP beds are delivered to hospitals direct from factory in specially equipped van operated by AMP personnel. Beds are checked and made ready for occupancy by AMP technicians.

8—AMP bed has UL approval for use with oxygen and meets UL safety requirements.

AMERICAN METAL PRODUCTS COMPANY

DETROIT 4 amp® MICHIGAN

The same type of smooth and quiet electrical mechanism, designed and introduced by the American Metal Products Company for 4- and 6-way power automobile seat adjusters, is used thru-out this all-electric bed . . . a type of mechanism that has proved successful for over 6 years . . . and is exclusive with this bed.

For the convenience you want...
the safety you need...

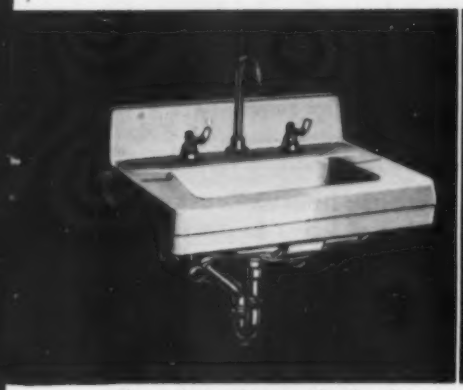
the choice is CRANE

Why have so many hospitals standardized on Crane plumbing equipment?

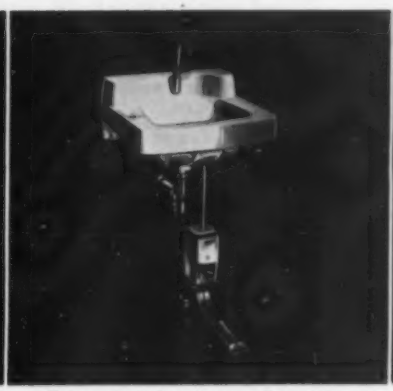
Convenience of use is one answer—fixtures especially designed to save time for the hospital staff. *Sanitary safety* is another—assurance of correctness in every detail that helps combat cross-infection. *Easy care and maintenance,* too, are special Crane advantages.

Crane offers a wide choice of plumbing fixtures for every department of your hospital. You can choose fixtures that suit your individual preferences and techniques. For your new or remodeled building, you'll find it worthwhile to discuss Crane qualifications with your architect.

A favorite in many hospitals—Crane Mayo surgeons' scrub-up sink, with convenient knee-action valve. Made of Duraclay, a special vitreous glazed Crane material, its hard, smooth surface will not pit, crack or craze . . . is impervious to stains, unaffected by acids or ordinary cleansing powders.



Convenient wrist operation is a feature of this Crane *Norwich* vitreous china lavatory. Gooseneck spout accommodates pitchers, vases, etc.

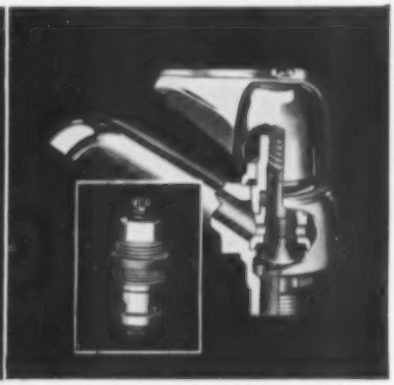


Foot-operated valve on Crane *Oxford* vitreous china lavatory prevents cross-infection. Hands never touch faucets.

Hygiene lavatory is ideal for patients' rooms. Available for right- or left-hand corner installation, also, without side splash.

Crane *Coolbrook* vitreous china, semi-recessed drinking fountain has elevated bubbler base for maximum sanitation. Available with single or central water chiller.

Crane *Institutional* free-wall bath, to build into end wall. Made of durable cast iron with porcelain enamel finish. Cast iron base included.



A Crane exclusive—*Dial-ese* control—practically drip-proof because it closes *with* water pressure, not against it. All working parts contained in low-cost replacement unit.

Infants' bath made of Crane *Duraclay*. Smooth, vitreous china surface is kind to babies' skin. Includes 20-gallon tank with dial thermometer.

The *Cornell*, one of several service sinks in the Crane line. Has flushing rim and siphon jet flushing action. *Duraclay* construction assures long service, easy maintenance.

Crane *Placidus* closet has whirlpool, quiet-action bowl and flush valve that minimize noise. Has elongated rim, open front seat.

CRANE®

THE PREFERRED PLUMBING

CRANE CO., 836 SOUTH MICHIGAN AVENUE, CHICAGO 5, ILL. • VALVES • FITTINGS • PIPE • PLUMBING • HEATING • AIR CONDITIONING

(*Continued From Page* 148)
plete and coordinated health care for our communities."

Mr. Terrell said there was merit in the concept of progressive patient care, where "Jones pays just for what he gets, and no part of the cost of what Smith gets."

Frank S. Groner, administrator of Baptist Memorial Hospital, Memphis, and immediate past president, American College of Hospital Administrators, urged administrators to consider facilities and services that provide extra hospital revenue as a means of improving hospital service. Office buildings for physicians provide "extra revenue" facilities which are acceptable to the community, for example, Mr. Groner said.

Another source of revenue is the visitors' parking lot, he pointed out. Pay parking is a legitimate source of revenue for the hospital, he said; "free" parking must actually be paid for by patients and is thus an unfair burden on the sick, he added.

"It would appear that there are avenues open to hospitals which very definitely contribute to elevation of the level of medical and hospital service rendered to patients, which is the primary consideration, and, in addition, afford hospitals another tool to keep the cost of hospitalization at the minimum," Mr. Groner concluded.

Increase in Blue Cross Hospital Days Reported

Miami. — Blue Cross members were hospitalized more than two million days more in 1958 than in the previous year, according to the annual report released April 12 by the Blue Cross Commission of the American Hospital Association during the annual conference of Blue Cross plans meeting here.

The commission presented its Justin Ford Kimball award to George A. Newbury, president and chairman of the board of Hospital Service Corporation of Western New York for the last 13 years. He was honored with the award commemorating the founder of Blue Cross because of "outstanding encouragement given to the concept of voluntary prepaid health care plans," the commission stated.

Nearly $40 million had to be taken from reserves of individual Blue Cross plans to pay for the total of about 57⅛ million days of hospital care for members, the annual report noted.

As the trend has been during recent years, the commission said, more Blue Cross members were hospitalized for illness during 1958 than ever before; they used a larger number of the hospital services available, and Blue Cross paid more to hospitals for their care.

For the 55,880,414 persons enrolled in the Blue Cross program to prepay the cost of hospital illness, there were 10,088,504 hospital admissions. Patients were in the hospital a total of 57,530,459 days and the average length of stay was seven and one-half days. Blue Cross paid hospitals $1,346,948,510—a record amount and nearly $150 million more than was paid in 1957, the report stated.

Wins Safety Award

Chicago. — Roanoke Memorial Hospital, Roanoke, Va., has been announced grand award winner of the 1958 hospital safety contest cosponsored by the American Hospital Association and the National Safety Council. The hospital, with 530 employes, operated 1,168,346 man-hours last year without a reportable injury.

LOOK *at the advantages of "Tamed Iodine"®*

WESCODYNE®

FEATURES OF TAMED IODINE AGAINST OTHER TYPES OF DISINFECTANTS

	Chlorines	Quats	Creosols	Pines	Synthetic Phenols	WESCODYNE
Microbial Activity	Very short	Variable	Intermediate	Poor to variable.	Intermediate	High
Stability	No	Yes	Yes	Yes	Yes	Yes
Cost in Use	Low, but require frequent application.	High	High, too much needed.	Low, but require frequent application.	Moderate to low.	Very low.
Odor	Heavy and penetrating.	None	Heavy	Heavy and lingering.	Some are heavy, others linger.	Very light and non-lingering.
Cleaning Ability	None, cause bleaching.	Poor, inactivated by soaps.	Good	Good	Good	Good
Microbiology	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	A nonselective germicide. Kills bacteria, virus, molds, fungi, yeast, spores, etc.
Affected by Hard Water	No	Yes	Yes	Yes	In some cases.	No
Indicator of Bacterial Efficiency	None	None	None	None	None	Color
Effect on skin, full strength	Irritants	Sensitizers	Irritants	Non-irritating	Irritants	Non-irritating
Toxicity	Yes	Variable	Yes	No	Yes	No

EXTRAORDINARY GERMICIDE

WESCODYNE is the *first "Tamed Iodine" hospital germicide.* It offers extraordinary advantages. Nonselective biocidal activity. A cleansing detergent action. Extremely low cost. And more, as indicated in the above comparison.

Important, too, tests on common pathogens show that WESCODYNE offers greater germicidal capacity for the control of cross infection.

WESCODYNE is the single germicide suitable for all hospital cleaning and disinfecting procedures. Its labor-saving detergent action removes soil and dust as germs are destroyed. This simplifies procedures, including those for the decontamination of surfaces that harbor "Staph" and other organisms.

WESCODYNE costs less than 2¢ a gallon at its general-purpose use dilution. It has an unmatched history of scientific evaluation and success. We'd be glad to send full information, a sample and recommended O.R., housekeeping and nursing procedures. Just call your nearby West office. Or send the coupon below to our Long Island City headquarters, Dept. 25.

☐ Send a WESCODYNE sample and full information.

☐ Have a representative phone for an appointment.

Name_____

Position_____

PROGRAMS AND SPECIALTIES
FOR PROTECTIVE SANITATION
AND PREVENTIVE MAINTENANCE

WEST CHEMICAL PRODUCTS INC.

WEST DISINFECTING DIVISION

WEST CHEMICAL PRODUCTS INC.
42-16 West Street, Long Island City 1, New York
Branches in principal cities
CANADA: 5621-23 Casgrain Avenue, Montreal

For additional information, use postcard facing Cover 3.

Better Use of Facilities Needed, Quebec Hospital Association Congress Told

MONTREAL, QUE. — Quebec hospitals should make better use of present facilities before undertaking to build new wings and further expansions, the nearly 2000 delegates at the first annual congress of the Quebec Hospital Association were told here at their March meeting.

Dr. Arthur Leclerc, Quebec minister of public health, also asserted that, "Many hospitals are overcrowded with patients who could just as well be treated at home. They are in the hospital for the staff doctor's convenience or because they have private hospital insurance."

Referring to Quebec's hesitation to participate in the National Hospital Insurance Plan, Dr. Leclerc stated, "Quebec would enter the national plan only under conditions most suitable to its constitution."

The hospital as a community health agency affiliated with other social and health agencies was stressed by Raymond P. Sloan, associate professor of administrative medicine, Columbia University, and chairman of the editorial board of The MODERN HOSPITAL.

He urged closer cooperation among all community health agencies in future planning under the leadership of trustees, administrators, medical staff members, nursing heads, auxiliary members, and other key figures. "Such effort would be not only in the direction of future needs, but new approaches to meeting the emotional needs of the patient," he said.

"Having set the pattern of health care, we have need to interpret it and sell it as a complete package to the public," Mr. Sloan continued. "We have not yet been successful in selling the public on the services our hospitals are rendering. There still remains to be accomplished an educational campaign so compelling that people will cease to make comparisons between hotel and hospital charges."

Dr. Paul Bourgeois, executive director, Notre Dame Hospital, Montreal, was installed as president. Hon. Judge Thomas Tremblay, Quebec, was named vice president and A. H. Westbury, executive director, Montreal General Hospital, treasurer.

Consider State Bill on Qualifications for Hospital Practice

COLUMBUS, OHIO. — Proposals for a state law that would specify professional and ethical standards for doctors practicing in hospitals were under consideration here last month.

The proposals represented a compromise between hospital and medical representatives and State Senator Frank W. King of Toledo, who had previously submitted a bill which would permit any physician licensed to practice in Ohio to care for patients in any hospital in his home county, provided the physician had served in the armed forces in World War II or the Korean War and had completed an internship in an Ohio hospital.

Senator King's bill, it was reported, had been submitted on behalf of Dr. Louis T. Odesky, Toledo physician who reportedly cannot practice in Toledo hospitals because he is not a member of the Academy of Medicine.

Hearings on Senator King's bill were scheduled to begin last March but were canceled following a conference between Senator King and representatives of the state hospital and medical associations, it was reported.

FREE OFFER!

Post CEREALS

to prove that Instant Maxwell House is better for your operation than ground coffee!

The experience of successful users of Instant Maxwell House Hotel and Restaurant Coffee has proved that it is better than ground coffee for food service operations. Instant Maxwell House H&R Coffee was developed especially for the food service industry. We want you to try a free supply because we know you'll continue to serve it. And here are the reasons why:

- Instant Maxwell House has *uniformity of flavor*. Day in, day out, you can serve the same delicious cup of coffee!
- Instant Maxwell House offers *substantial economy*. Gives 10% greater yield. No coffee is wasted in grounds.
- Instant Maxwell House *can be made by anyone*—with your present equipment or in a special instant coffee machine, if you desire.
- Instant Maxwell House *saves labor*, eliminates 3 out of every 4 man-hours now spent in preparing ground coffee.
- And—Instant Maxwell House has proven consumer acceptance—it is *America's largest-selling coffee!*
- It is conveniently packaged in urn-size, glassmaker-size, and individual envelopes.

Yes, Instant Maxwell House is better for your operation than ground coffee—and you can prove it for yourself! Mail the coupon below for a FREE one-day trial supply of coffee and demonstration. There's no obligation to buy.

A Product of General Foods

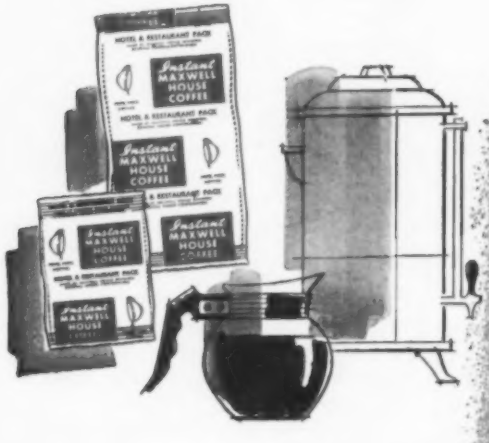
INSTANT SANKA COFFEE

Log Cabin Syrup

good seasons
SOUP BASES AND SEASONINGS

MAXWELL HOUSE COFFEE

JELL-O DESSERTS



FREE OFFER

General Foods Corporation
Institutional Products Division
White Plains, New York Dept. V

We're interested in a free one-day trial supply of Instant Maxwell House H&R Coffee and a demonstration. I understand we are under no obligation to buy.

Name..... Title.....

Organization.....

Address.....

City..... State.....

Equipment used (check one) ☐ Urn ☐ Glassmaker
Number Cups Served Per Day .....

GF INSTITUTIONAL PRODUCTS DIVISION

GENERAL FOODS CORPORATION
INSTITUTIONAL PRODUCTS DIVISION
WHITE PLAINS, N. Y.

New England Assembly Elects Dr. Geetter

(*Continued From Page 66*)

and acute diseases less than 10 per cent. The chronic disease category has as the two major components cardiovascular renal diseases and cancer. These two groups of conditions already account for 70 per cent of all deaths. Deaths from chronic disease tend to concentrate in the older age group. It seems fair to predict, therefore, the quantitative aspect of medical service will continue to shift up the age spectrum and that an increasing quantity of our medical service output will be for chronic illness in the older persons."

Speaking at the same session, C. Rufus Rorem, executive director of the Hospital Council of Philadelphia, suggested that hospitals should charge more for room and board but less for medical services. He argued that higher room charges would encourage shorter stays, while lower cost of other services would encourage their greater use and improve the quality of care.

Mr. Rorem defended hospitals against charges of inefficiency in management. "Hospitals are as well managed as hotels, department stores, or other agencies dealing in commodities and services," he asserted. "No business institution would be expected to give away a substantial portion of its product, unless some group stood ready to reimburse the firm in some manner. It isn't what a hospital sells that causes financial worry, but what it gives away. The general public has not always been willing to assume full responsibility for payment for the 'free' services rendered by hospitals at public request or demand."

The afternoon trustee session was devoted to the problems of small community hospitals. In discussing "What Services Will Be Offered in Tomorrow's Hospital," Abbie E. Dunks, administrator of the Boston Dispensary, got off to a brisk start by reminding her audience that "The more we ask unwilling customers to pay more for services they don't want, the more our public relations deteriorate." She urged hospitals to "move out into the market place" and sell themselves to the public through an intensive program of education. The four major areas of hospital service, Miss Dunks said, are (1) promotion of positive health; (2) prevention of disease; (3) alleviation of disease, and (4) rehabilitation or "restoration."

Miss Dunks recommended regional affiliation for small hospitals to avoid overlapping of services and duplication of expensive equipment. Instead of building more beds where they aren't really needed, hospitals should make full use of existing facilities, she urged. For example, idle beds could be used for convalescent or diagnostic patients or by older people who need care during the day and can be sent home to their families at night. Community hospitals must take the responsibility for making needed changes now, Miss Dunks asserted, and not be appeasers "who feed the crocodile in the hope that it will eat them last." In conclusion, she warned that "if we don't climb out of our rut pretty soon, there won't be any community hospitals."

The hospital trustee is responsible for determining community needs and he cannot assign or delegate that responsibility, according to one of them — Walter Beinecke, trustee of Nantucket Cottage Hospital, Nantucket, Mass. Mr. Beinecke believes that the trustee's job is to keep the community educated in direct ratio to advances in professional care, and that this is a constant job — not something that can be done "just once in a while." In order to carry out his responsibility for interpreting the hospital to the community and the community's needs to the hospital, Mr. Beinecke said, the trustee "should have his nose in and his mind on everything that goes on in the hospital but not his hands. He should keep those off of the hospital operation," in Mr. Beinecke's view.

In addition to Dr. Geetter, the following officers and trustees were elected for the coming year: secretary, Wesley D. Sprague, New England Deaconess Hospital, Boston (re-elected), and treasurer, Pearl R. Fisher, R.N., Thayer Hospital, Waterville, Me. New trustees are: John L. Quigley, commandant, Soldiers' Home and Hospital, Chelsea, Mass., and Dana S. Thompson, Central Maine General Hospital, Lewiston.

Hospital Industries Association awards for the best booth displays were given to the following exhibitors:

First award for best single booth — Jones, McDuffee & Stratton, Inc., Boston; honorable mention — Brisk Waterproofing Co., Inc., Boston.

First award for best multiple booth — American Sterilizer Company, Erie, Pa.; honorable mention — Hill-Rom Company, Batesville, Ind. ■

Nurses Warned Against Loss of "Human Approach" at Iowa N.L.N. Meeting

IOWA CITY, IOWA. — Nurses can quickly lose the human approach to caring for patients in a welter of details, pressure of problems, and conflicts of hospital policies, personnel and the patient's needs, Sister Mary Anthony, director of St. Margaret's Hospital School of Nursing, Kansas City, Kan., told members of the Iowa League for Nursing at their convention April 10.

The good nurse will not lose, in the maze of medical advances, "an eagerness to make certain that man is dealt with, sick or well . . . with dignity, with respect, and with love," Sister Mary Anthony said.

Both hospital nursing services and nursing schools must work together to instill in the young nurse this attitude toward her work and prepare her to adapt nursing service to the rapid changes the future will bring, she explained.

Many a student nurse loses her idealism as she works with nurses who have lost it, Sister Mary Anthony said.

Both she and Margaret Giffin, director of the National League for Nursing department of hospital nursing, said they felt that hospitals can give better nursing care without additional personnel if they will work further on using their present staffs as efficiently as possible.

Herbert Thelen, professor at the University of Chicago, outlined some policies to get any group to work effectively: Assume that anyone giving an idea must be responded to in some way — don't ignore even poor ideas. After the idea has been presented, the individual should consider that it belongs to the group, not to him. Assume that there are no "problem" people in your group. Until people are willing to work to solve a problem, they haven't really recognized it exists. Don't try to reach a group decision by taking a vote until the group is in nearly complete agreement — postpone the vote until after further discussion, he said.

Ohio Association Names Gettman President-Elect

A. S. Dickens

COLUMBUS, OHIO. — John C. Gettman, administrator of Memorial Hospital, Fremont, Ohio, was named president-elect of the Ohio Hospital Association at its annual convention here April 6 through 9.

Anthony S. Dickens, executive director of City Hospital, Springfield, was installed as president. He succeeds Roger Sherman, administrator of Children's Hospital, Akron. Other officers elected were Harold A. Zeally, Memorial Hospital, Elyria, first vice president; Sister Mary Gabriel, Mercy Hospital, Tiffin, second vice president, and Lee S. Lanpher, Lutheran Hospital, Cleveland, treasurer.

Methods of getting the hospital story told to the general public and the role of the medical staff and employe in an interpretation of the hospital to the community were discussed. Among the speakers were George Bugbee, president of Health Information Foundation, and E. M. Friedlander, director of public relations, Pratt Diagnostic Clinic, New England Center Hospital, Boston.

(*Continued on Page* 161)


tomorrow's
laundry machine...
proving itself!
You get more from
American
THE AMERICAN LAUNDRY MACHINERY COMPANY

First this machine must survive an obstacle course . . . continuous operation under everyday working conditions in an actual laundry. When you buy an American machine you know that every last detail has been carefully checked by our test engineers. You can be sure *your* American machine has already done everything you could ask, and more!

This laundry machine is a pre-production model, one of many of its kind undergoing grueling field tests in different types and sizes of laundries throughout the country. These tests continue for months — in some cases more than a year — until we're sure the equipment is right for you!

Besides field tests, your American machine has proven itself in electrical tests, metal tests, chemical tests as well as mechanical and operational tests — the industry's most complete series of tests. We include every conceivable combination of soaps, formulas, types of work or methods of operation used anywhere in the world!

The fact that we put a new machine on the market — is your proof that it has passed these tests, that it will give you continuing reliable performance for years and years. This is another important reason you get *more* from American.

You get more from... American

The American Laundry Machinery Company, Cincinnati 12, Ohio

Shift of Traditional Services Outside Hospital Framework Is Called Alarming

CHICAGO. — A leading spokesman for the Blue Cross movement recently assailed the tendency on the part of some hospitals to reduce the scope of services considered an integral part of the "package" of health care purchased by the patient.

"To an alarming extent, at least in some parts of the country, items that have been traditionally accepted as a hospital service have been shifted outside the framework of hospital prepayment—and sometimes outside hospital service," said Dr. Basil C. MacLean, president of the Blue Cross Association.

He declared, "Where the patient once received a single bill for a 'package' of hospital services, more often than not he may receive today a bewildering assortment of separate bills for each hospital admission."

Dr. MacLean spoke before a group discussion panel at the National Health Forum assembled by the National Health Council. The panel considered economic factors in providing health care to the nation's workers, within the framework of the over-all theme, "The Health of People Who Work."

A former commissioner of hospitals for New York City, Dr. MacLean said, "The idea has grown in the public mind that the hospital is more than an emergency stop for repairs, but rather a package of the varied skills and technics needed for full health services—periodic screening and early detection of disease, diagnosis and treatment." He sketched the future hospital as a "community health center" with extended outpatient services covered by prepayment and insurance.

The figures given on the number of Americans who buy health insurance are often misleading, the Blue Cross executive said. "A closer inspection of the benefits being bought by some of these 120 million Americans reveals small cause for complacency." He called upon prepayment plans and insurance to cover all necessary hospital admissions.

"Coverage" he said "is long overdue for admissions for short-term treatment of tuberculosis, acute mental illness — in short, all admissions that advancing medical progress deems appropriate to hospital care. Chronic care, rehabilitation and convalescence should be covered as an extension of hospital service."

While citing the need for expanded hospital services under prepayment, Dr. MacLean also raised the challenge of extending health protection to population groups who are not as yet covered. Among these he included all dependents of the wage-earner, disabled and unemployed workers, casual worker, self-employed, and aged.

"It is significant," he said, "that the unenrolled body of our people contains those who need hospital care the most and who can afford it least as an out-of-pocket expense. . . .It is because the unenrolled hard-risk elements of the population have been largely overlooked in the past that the whole voluntary prepayment movement is on the spot today."

Dr. MacLean admitted the formidable cost problems raised by such extension of benefits and broader coverage of the population. However, he stated, no "new" costs were involved. Health services are being bought, re-

For additional information, use postcard facing Cover 3.

gardless of the way in which they are organized or financed, "too often. . . under conditions of hardship and indignity for the individual, and economic disorder and waste for the community." The main question, he said, was how to organize and distribute the cost most efficiently and economically—"What form of social organization will make the most health services available to the people?"

Ultimately the public will decide, Dr. MacLean declared, on a prepayment mechanism that operates "under the general kind of public franchise now accorded to Blue Cross. The main mandates of this franchise are nonprofit operation, public participation in policy making, service benefits, and rating practices that reflect community needs and goals."

University Hospital Stops Care of Michigan Indigent

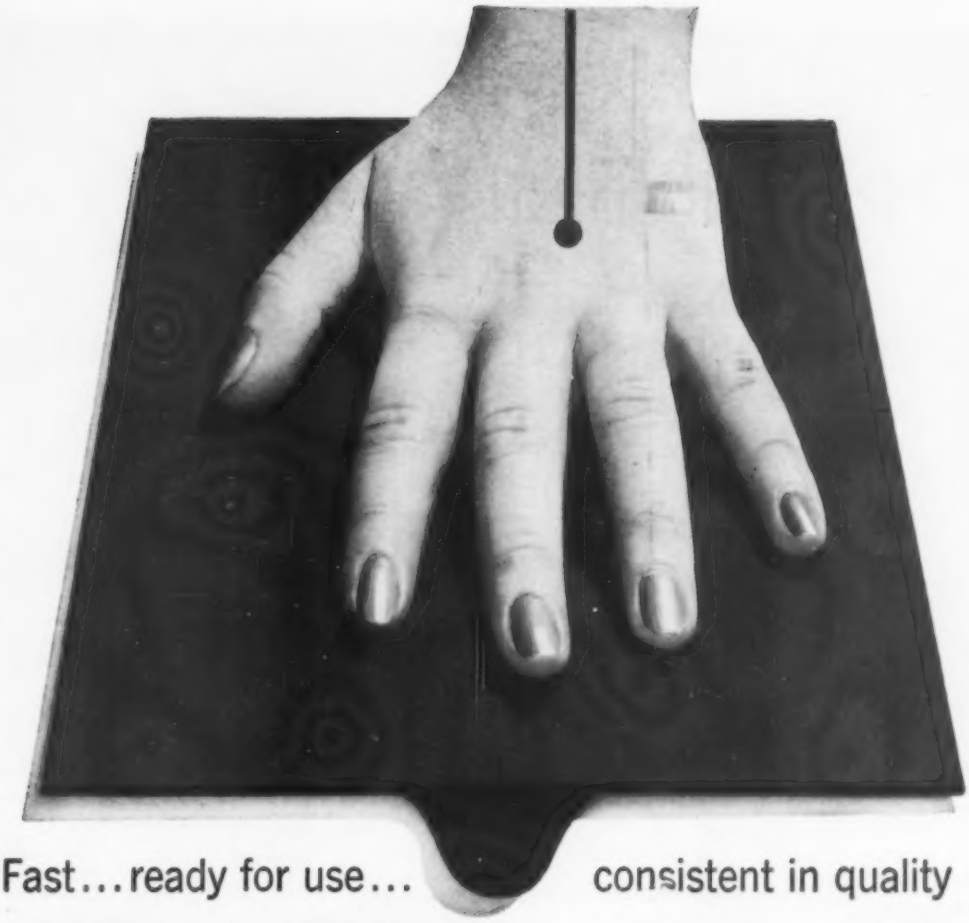
ANN ARBOR, MICH. — University Hospital, a self-supporting unit of the University of Michigan Medical Center, has refused to accept patients from state institutions except in emergencies, according to a decision announced last month by Dr. A. C. Kerlikowske, hospital director.

The hospital said that the state was more than $500,000 behind in payments for the care of its medically indigent. Stating that hospital finances are "in as precarious a position as the state proper," Dr. Kerlikowske said only emergency cases will be handled until funds are again made available. Over the last 10 years, he reported, University Hospital has lost $895,000 through actual services (excluding doctors' fees) rendered to the Michigan Crippled Children's Commission alone. If current charges to the Commission go unpaid, this figure will reach $1,147,000, he said.

Open Mental Health Drive

NEW YORK. — The annual campaign of the National Association of Mental Health to raise funds and focus attention on the problems of mental illness began April 26 and continues through the month of May. The campaign is stressing the fact that 70 per cent of those suffering from mental illness can recover with proper care and treatment.

(*Continued on Page 166*)



Fast... ready for use... consistent in quality

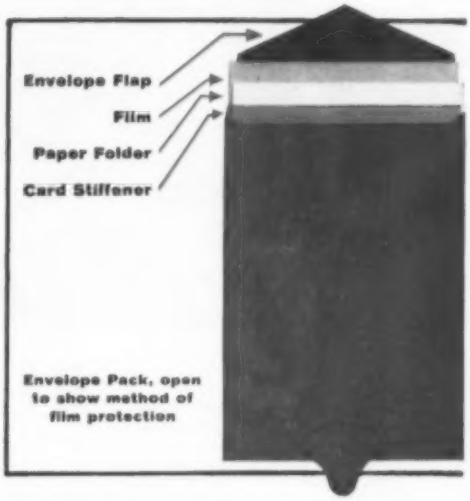
ILFORD ILFEX *Envelope Pack*

a superior x-ray film for non-screen radiography

THE FILM: Your radiologists and technicians will welcome this ultra-fast high contrast emulsion, which consistently produces superb non-screen radiographs. Ilfex X-ray film provides exceptional bone and tissue detail—far superior to that which can be obtained with conventional screen techniques.

THE PACKING: The Ilfex Envelope Pack is ready for instant use without darkroom preparation and makes an excellent storage envelope for developed radiographs. The film is securely sealed against fog, artifacts and contamination. Supplied in boxes of 25, in all standard sizes.

If your hospital has not yet tested Ilfex, and would like to do so, please contact any of the following for a no-cost demonstration: General Electric, Keleket, Picker, Westinghouse or their authorized dealers.



Envelope Pack, open to show method of film protection

ILFORD INC. 37 WEST 65th STREET, NEW YORK 23, N.Y.

IN CANADA: Canadian distributors for Ilford Limited, London: W. E. Booth Co., 12 Mercer St., Toronto 2B

How hospitals eliminate a dangerous source of bacteria– Airborne Dirt

The Honeywell Electronic Air Cleaner removes 95% of all dirt that passes through the air handling system

The accumulation of germ-laden dirt and dust in the ventilating and air conditioning ducts creates a hidden menace in the heart of the hospital. It is *vital* to keep these areas as free of dirt and dust as possible.

Dirt and dust in ducts can mean the presence of disease-causing bacteria and virus. The Honeywell Electronic Air Cleaner traps dirt and dust particles as small as 1/25,000,000 of an inch.

The Honeywell Air Cleaner is the most practical method for obtaining clean air. It is 6 *times as effective* as ordinary mechanical filters, and is a permanent air cleaner, requiring only periodic washing to maintain maximum efficiency.

A Health Menace: HIDDEN DIRT—In ventilating ducts, dirt accumulates out of sight and out of reach. As the illustration above indicates, this hidden dirt creates an unsanitary condition in the heart of the hospital.

The Honeywell Air Cleaner Is 6 Times More Effective Than Ordinary Mechanical Filters

Ordinary mechanical filters trap only 15% of the airborne dirt that passes through the air conditioning and ventilating systems. And every cubic foot of air that enters carries *millions* of dirt and dust particles.

Of course, dirty ducts are only a *part* of the cleanliness picture in the hospital. Everyone knows that hospitals are scrubbed clean many times a day. But to effectively combat this important *airborne dirt* problem—and make your ventilating air and air conditioned air as clean as possible—you can depend on the Honeywell Electronic Air Cleaner.

Coupled with the Activated Charcoal Filter, the Honeywell Air Cleaner removes odors, too. This could result in a saving of air conditioning operating expenses through reduced use of outdoor air for odor dilution.

For full information, telephone your nearest Honeywell office. Or write: Minneapolis-Honeywell, Department MH-5-09, Minneapolis 8, Minnesota.

Honeywell

H HONEYWELL First in Control

Hospital-Blue Cross Honeymoon Over, A. H. A. Officer Says

(*Continued From Page* 136)

out regard for the age, employment, finances or health status of the persons covered; the programs must be so devised as to permit hospitals, prepayment plans, and the public to work together in a three-way partnership.

6. Hospitals and Blue Cross plans face increasing legislative interest in their operations and must develop voluntary controls to limit excessive utilization and inefficiency.

Two speakers at the convention urged hospitals to seek accreditation. Dr. Denver Vickers, assistant director of the Joint Commission on Accreditation of Hospitals, Chicago, said the same accreditation standards applied for large and small hospitals and urged small hospitals, especially, to seek accredited status.

Everett W. Jones, hospital consultant of Fort Myers Beach, Fla. said: "You know, your doctors know, I know, and I wish all your hospital trustees and patients knew that an unaccredited hospital is an inferior hospital and one which may be an unsafe place for patients."

Mr. Jones urged even stricter accreditation standards than those that prevail today, and more thorough inspections by accreditation surveyors. He also urged hospitals to conduct medical audits as a means of improving professional performance.

In addition to Mr. Kidd, other officers elected by the association were: vice president, Robert Eleazer, assistant administrator, St. Luke's Hospital, Jacksonville, Fla.; trustee at large, D. O. McClusky Jr., administrator, Druid City Hospital, Tuscaloosa, Ala.

85 per Cent of Aged Report Health Complaints

NEW YORK. — About 85 per cent of the persons over age 65 interviewed recently for the Health Information Foundation said they had some health complaint or other illness that bothered them within the previous four weeks, the foundation reported last month. Only one-third of the persons interviewed who had a health complaint had told a physician about it.

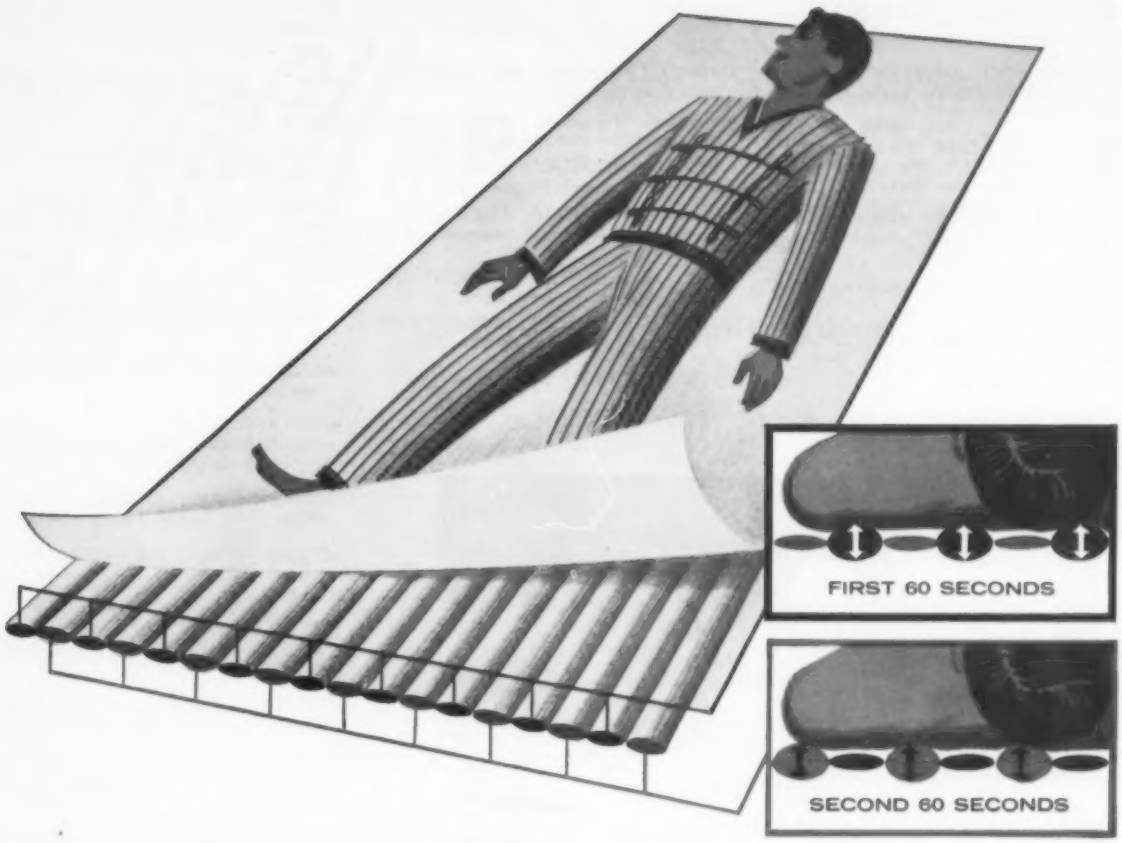
Persons 65 and over were found to average 7.6 visits to doctors a year per capita, or about two visits a year more than the average for all age groups in the country. The survey also showed that almost two out of every five older persons had not seen a doctor during the previous 12 months and 10 per cent of the survey group had not been to a physician in five years or more.

"Economic factors seem to be a relatively minor element in this reluctance to see a physician," said George Bugbee, foundation president. Even though incomes are generally lower among the older age groups, only 3 per cent of all persons 65 and older said they had delayed consulting a physician because of the cost, he said.

Early results of the survey were published in the foundation's monthly bulletin, *Progress in Health Services*.

Hospital Plans Apartments

NEW YORK. — Plans for a 19 story apartment house of 141 units, to be sponsored by Beth Israel Hospital and built adjoining it, were announced recently by controller Lawrence E. Gerosa. A mortgage application for $1,950,000 or 98.5 per cent of the total construction cost has been approved, Mr. Gerosa said.



Tired of Fighting the Bedsore Problem?

APP Units Are the Proved Way to Help Cure and Prevent Decubiti

The Alternating Pressure Pad helps prevent and cure decubiti by automatically shifting body pressure points every two minutes as illustrated . . . thus maintaining adequate circulation and preventing tissue breakdown. The combination of an APP Unit and normal nursing care starts granulation usually within a few days.

Equally important, APP Units eliminate the constant turning of patients, (which in some cases adversely affects recovery) and provide passive massage on a 24-hour basis.

Thousands of APP Units are now in use. Many more are needed for private patients in hospitals and nursing homes. Units are available from leading surgical supply houses for standard beds, respirators and wheel chairs.

APP Units are manufactured solely by Air Mass, Inc., Cleveland, Ohio, U. S. A.

MAIL THIS COUPON FOR ACTION

THE R. D. GRANT COMPANY
805A Hippodrome Building
Cleveland 14, Ohio, U. S. A.

☐ Please send complete details on APP Units.
☐ Please send APP Unit Clinical Reports.
☐ Please have your representative call me to arrange a demonstration.

Institution_____
Street_____
City_____ Zone_____ State_____
Requested by_____

COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Radisson Hotel, Minneapolis, Oct. 12-15.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Convention and Annual Meeting, New York, Aug. 23-26.

AMERICAN DIETETIC ASSOCIATION, Shrine Auditorium, Los Angeles, Aug. 25-28.

AMERICAN GERIATRIC SOCIETY, Atlantic City, June 4, 5.

AMERICAN HOSPITAL ASSOCIATION, The Coliseum, New York, Aug. 24-27.

AMERICAN MEDICAL ASSOCIATION, Convention Hall, Atlantic City, June 8-12.

AMERICAN NATIONAL RED CROSS, Atlantic City, June 1-3.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs, May 18, 19.

ARIZONA HOSPITAL ASSOCIATION, Monte Vista Hotel, Flagstaff, Oct. 8, 9.

CANADIAN HOSPITAL ASSOCIATION, Queen Elizabeth Hotel, Montreal, May 11-13.

CATHOLIC HOSPITAL ASSOCIATION, Kiel Auditorium, St. Louis, June 1-4.

COLORADO HOSPITAL ASSOCIATION, The Antler's Hotel, Colorado Springs, Oct. 8, 9.

COMITE DES HOPITAUX DU QUEBEC, Montreal Show Mart, Montreal, Que., June 24-26.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 1.

IDAHO HOSPITAL ASSOCIATION, Elks Lodge, Boise, Oct. 19, 20.

INTERNATIONAL HOSPITAL CONGRESS, Assembly Rooms, Edinburgh, Scotland, June 1-6.

JOINT COUNCIL TO IMPROVE THE HEALTH CARE OF AGED, Sheraton Park Hotel, Washington, D. C., June 12-14.

MAINE HOSPITAL ASSOCIATION, Hotel Samoset, Rockland, June 2, 3.

MARYLAND-D.C.-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D. C., Oct. 26-28.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, May 14.

MICHIGAN HOSPITAL ASSOCIATION, Sheraton Cadillac Hotel, Detroit, June 21-23.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N. J., May 20-22.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, Oct. 7-9.

NATIONAL LEAGUE FOR NURSING, Convention Hall, Philadelphia, May 11-15.

NATIONAL REHABILITATION ASSOCIATION, Boston, Oct. 26-28.

NATIONAL TUBERCULOSIS ASSOCIATION, Palmer House, Chicago, May 24-29.

NEW HAMPSHIRE HOSPITAL ASSOCIATION, Mountain View House, Whitefield, June 18, 19.

NORTH CAROLINA HOSPITAL ASSOCIATION, Mayview Manor, Blowing Rock, June 10-12.

OREGON ASSOCIATION OF HOSPITALS, Coos Bay, Oct. 19, 20.

SASKATCHEWAN HOSPITAL ASSOCIATION, Bessborough Hotel, Saskatoon, Oct. 14-16.

TEXAS HOSPITAL ASSOCIATION, Shamrock-Hilton Hotel, Houston, May 12-14.

UPPER MIDWEST HOSPITAL CONFERENCE, Auditorium, St. Paul, May 13-15.

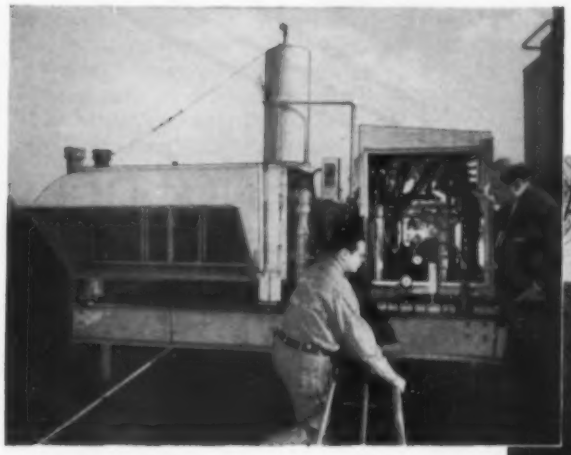
Ability To Pay Increases

MINNEAPOLIS. — The American consumer's ability to pay past due bills increased slightly during the first quarter of 1959, according to the collection index released by the American Collectors Association, Inc. The leading reason for overdue debts was attributed to unemployment in several regions, the report said.

HIGH IN THE SKY...

DUNHAM-BUSH

Air Conditioning Installation for Hospital's "HEART" Below



MOTHER CABRINI MEMORIAL HOSPITAL
New York City, New York
Supervisor: Mother Charitas, MSC

Contractor: Edison Cooling Systems, Inc.
Wholesaler: Albert Hofeld, Inc.

Vital to all hospitals is efficient and uninterrupted functioning of operating rooms, doctors and nurses scrub rooms . . . "heart" of the institution's activities.

High on the roof of New York's Mother Cabrini Memorial Hospital is a complete outdoor installation for air conditioning these important areas. The entire system was installed during a normal working day with practically no loss of operating time.

Dunham-Bush sales engineers worked closely with hospital authorities and suppliers to insure a highly efficient system that could be easily installed. All Dunham-Bush equipment including package chiller with pump, air handling unit and Brunner-Metic compressor insure dependable operation for years to come.

You are assured of the best when you deal with Dunham-Bush for hospital air conditioning and heating. Send for data on Dunham-Bush's many contributions to better hospitals throughout the country.

Dunham-Bush, Inc.

WEST HARTFORD 10 • CONNECTICUT • U. S. A.

DUNHAM-BUSH

AIR CONDITIONING • REFRIGERATION • HEATING • HEAT TRANSFER

For additional information, use postcard facing Cover 3.

NEW! BAUSCH & LOMB STEREOMICROSCOPES

FEATURING

STEREO ZOOM

CONTINUOUSLY VARIABLE POWER

Here's a completely new optical concept to speed and simplify work requiring 3D views. Just turn the magnification knob and watch the crisp stereo image zoom to the *exact* size you need. Not just a few fixed powers, but *any* power within the wide stereo range. The newest step forward to faster, easier 3D work . . . exclusive with Bausch & Lomb.

Featuring Exclusive **POWER POD Design Concept**

- Sealed to prevent dust and foreign matter from entering optical system!
- No nosepiece!
- No individual objectives . . . no objectives to change!
- No image jump!
- No image blackout!

Featuring **NEW LOW PRICE**
. . . about one-third lower than previous line!

BAUSCH & LOMB OPTICAL CO.
14841 St. Paul Street, Rochester 2, N. Y.

- ☐ Send me new B&L Stereomicroscope Catalog D-15.
- ☐ Schedule a demonstration at my convenience.
- ☐ I'd like to borrow a B&L Stereomicroscope for 15-day trial without cost or obligation.

Name, Title .....
Company .....
Address .....
City ..... Zone ..... State .....

BAUSCH & LOMB
SINCE 1853

America's only complete optical source . . . from glass to finished product

MAIL COUPON NOW!

ABOUT PEOPLE

(*Continued From Page 80*)

A. B. Anderson

A. Boyd Anderson has been appointed assistant administrator at West Penn Hospital, Pittsburgh. He was previously an administrative resident at the hospital and will be a candidate for a master's degree in hospital administration from the University of Pittsburgh in June. Previously Mr. Anderson was assistant superintendent of Washington Hospital, Washington, Pa., for nearly five years.

James Champer has been appointed assistant director of Weiss Memorial Hospital, Chicago. He is a graduate of Northwestern University school of hospital administration and had served as an administrative assistant at the hospital.

Leonard R. Piccoli has been appointed assistant administrator of Misericordia Hospital, Bronx, New York. He is a graduate of the school of public health and administrative medicine at Columbia University. He was previously administrative assistant at Montefiore Hospital, New York.

Clarence Murphy, administrator of Hubbard Memorial Hospital, Bad Axe, Mich., has resigned.

Sister Frances Michael has relieved **Sister Angela** as administrator of Sacred Heart Hospital, Pensacola, Fla.

Gladys Thomas, R.N., has been named superintendent of New London Hospital, New London, Ohio, succeeding **Helen Hansen,** who had served the hospital for the last four years. Mrs. Thomas holds the rank of colonel as an army nurse.

Bernard A. Mitchell, a former army medical corps officer who retired in 1953 after 25 years' service, has been appointed administrator of Normandy Osteopathic Hospital, St. Louis. He succeeds **Emil L. Herbert,** who has been named executive secretary of the American Osteopathic Hospital Association.

James K. Fisler has been appointed administrator of Scott County Memorial Hospital, now under construction at Scottsburg, Ind. He completed the course in hospital administration at Georgia State College.

Dr. William E. Murray, assistant superintendent of Madison State Hospital, Madison, Ind., has been named superintendent of the state hospital at New Castle, Ind. He succeeds **Dr. J. M. Mosier,** who resigned to enter private practice.

E.R. Andres has been appointed administrator of Grandview Hospital, Edinburg, Tex.

Glenn Bailey, assistant director of Niagara Falls Memorial Hospital, Niagara Falls, N.Y., has been named superintendent of Grand View Hospital, Sellersville, Pa. He will succeed **Nellie Hoffecker,** who resigned recently after more than 20 years as administrator.

John L. Haglund, business manager of Gregg Memorial Hospital, Longview, Tex., has been appointed to the newly created position of assistant administrator.

Dr. George W. Hobson, former manager of Veterans Administration Hospital, Excelsior Springs, Mo., has been appointed manager of Veterans Administration Hospital, McKinney, Tex.

Louis Felger has been appointed administrator of Goliad County Hospital, Goliad, Tex.

Booth Chilcutt, who recently re-

tired from the navy medical service corps with the rank of lieutenant-commander, has been named administrator of Monroe General Hospital, Key West, Fla.

H. G. Mann has been appointed administrator of Titus County Memorial Hospital, Mount Pleasant, Tex. He served previously as administrator of Rogers Memorial Hospital, Decatur, Tex.

Virgil W. Jackson, administrator of Samaritan Hospital, Moses Lake, Wash., has resigned to become minister of a church in Wenatchee, Wash. He will be succeeded as administrator by **Rodney E. Gannon.** Mr. Gannon was business manager of the hospital for four years before leaving a year ago to become business manager of St. Elizabeth's Hospital, Yakima, Wash.

James W. Cooke has been appointed administrator of Lynn Hospital, Lincoln Park, Mich. He was formerly assistant director of Akron City Hospital, Akron, Ohio. Mr. Cooke is a graduate of the program in hospital administration at Northwestern University and is a member of the American College of Hospital Administrators.

Kenneth E. Meredith, formerly administrator of Nashua Memorial Hospital, Nashua, N.H., has been appointed administrator of Alexander Linn Hospital, Sussex, N.J. Mr. Meredith is a graduate of the course in hospital administration at Columbia University.

Robert L. Finlayson has been appointed administrative assistant at Beth Israel Hospital, Boston. He is a graduate of the school of hotel administration at Cornell University.

Robert M. Gantt Jr. has been appointed director of hospitals, North Broward Hospital District, Fort Lauderdale, Fla. He was formerly administrator of Broward General Hospital there, where he has been succeeded by **Ernest C. Nott Jr.,** formerly administrative assistant at Broward General Hospital. **Robert E. Lee,** formerly assistant administrator at Broward General Hospital, has been appointed administrator of North District Hospital, Pompano Beach, Fla. **R. L. Nimmo** was recently appointed business manager of Broward General. He was formerly business manager of Riverside Hospital, Paducah, Ky.

Elsie R. Christiansen has been named administrator of Pacific Com-

6 MINUTES...

from exposed film...to processed radiograph

Save time... save space... give better service ...with the Kodak X-Omat Processor

Different from beginning to end—that's the Kodak X-Omat processing system.

No more film hangers. Exposed film is removed from cassette, fed directly into the unit. Six minutes later, a fully processed radiograph drops into the receiving bin—dry, ready to read.

Minimum floor space. Unit requires less than 25 square feet.

Uniform, high-quality radiographs. Roller-transport system combined with automatic replenishment eliminates processing variations.

Improved service. Film reading can begin 6 minutes after processing starts. No more wet readings—radiologist reads once, dictates one report. Over-all result: handles increased patient load today... ample capacity for years to come.

For further information, consult your Kodak X-Omat Processor dealer or write:

Medical Division
EASTMAN KODAK COMPANY
Rochester 4, N. Y.

Kodak

For reduced risk of cross-infection.....

use

B-D YALE

STERILE DISPOSABLE HYPODERMIC NEEDLES

a B-D product

STERILE, NONTOXIC, PYROGEN-FREE—a new, **B-D Controlled** needle for each injection. **TRULY DISPOSABLE**—color-coded inert plastic hub will not withstand conventional sterilization. **NEWLY DESIGNED POINTS**—smooth penetration every time. **TIME AND LABOR SAVING**—after-use servicing and handling eliminated.

B-D BECTON, DICKINSON AND COMPANY

maximum economy and convenience

B-D MULTIFIT

INTERCHANGEABLE SYRINGE WITH CLEAR GLASS BARREL

REDUCED BREAKAGE—barrel of clear, Resistance glass unweakened by grinding. **LOWER REPLACEMENT COSTS**—unbroken parts stay in service because **every** plunger fits **every** barrel. **EASE OF ASSEMBLY**—no tedious matching of parts—lower labor costs. **CONTROLLED FIT**—"backflow" eliminated—smoother operation.

RUTHERFORD, NEW JERSEY

munities Hospital, Newport, Ore., succeeding **Eugene Lasater. Rebecca Hammond** has been appointed director of nurses at the hospital.

W. Gordon Poole has resigned as administrator of St. Agnes Hospital, Raleigh, N.C., to join the state medical care commission as hospital analyst. **Ralph C. Bartlett,** who has served as assistant administrator, will succeed him as administrator.

J. R. Hill has been appointed administrator of DeLeon Memorial Hospital, DeLeon, Tex.

C. D. Cunningham, administrator of Cape Fear Memorial Hospital, Wilmington, N.C., since its opening, has resigned. **Herbert M. Kyle** is the new administrator.

Department Heads

Jennie Baker has been named associate director of nursing service and **Albert Reagan,** purchasing director, at St. Alexis Hospital, Cleveland. For three years Miss Baker was director of nursing at Lutheran Hospital School of Nursing, Cleveland. She has also served as director of nursing at East Orange General Hospital, East Orange, N.J., and Mansfield Hospital, Mansfield, Ohio. Mr. Reagan was formerly assistant procurement officer for City Hospital, Cleveland.

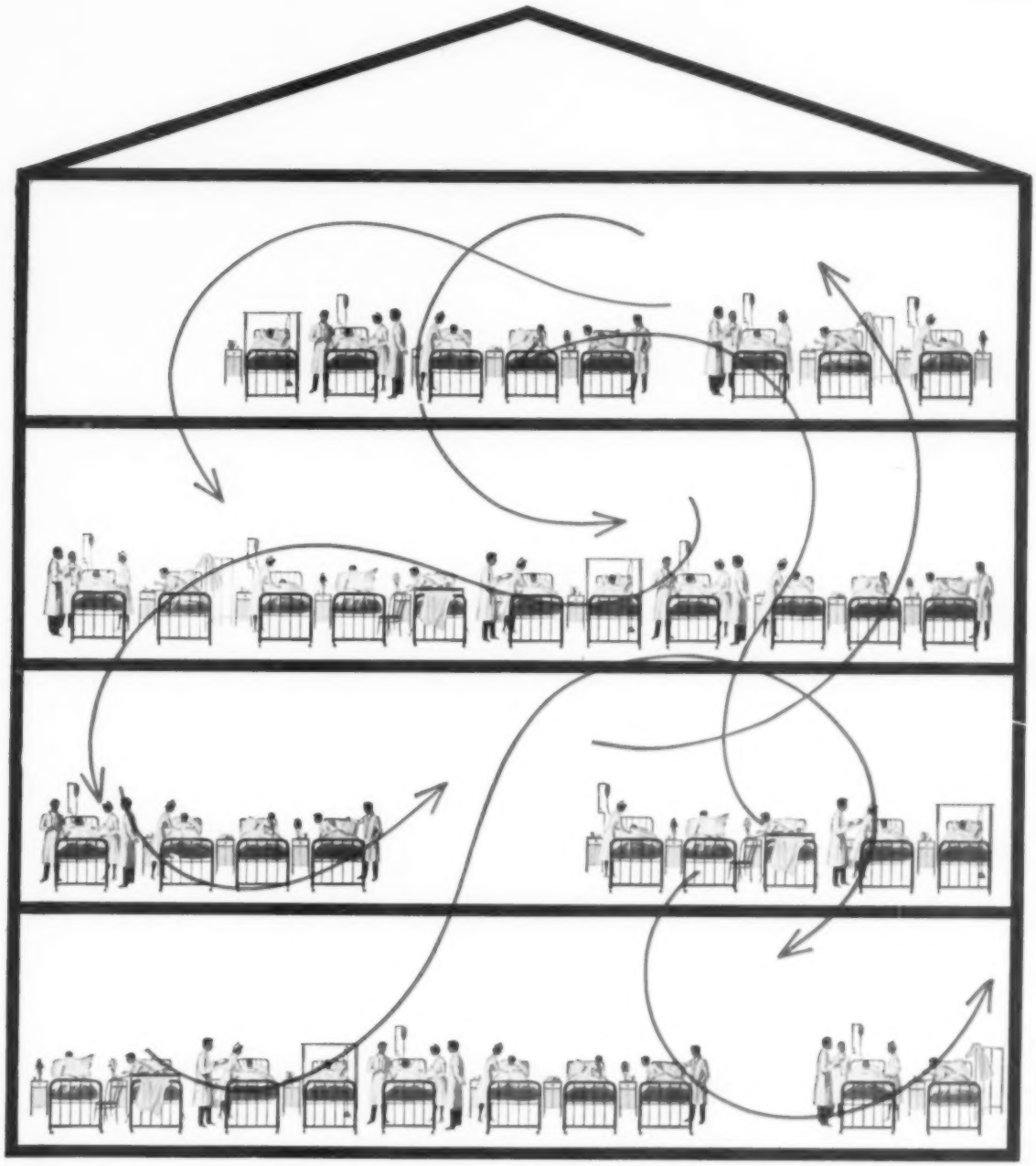
Phyllis M. Loucks has been appointed director of nursing at Butterworth Hospital, Grand Rapids, Mich. She has served as associate director of nursing since March 1958.

Arlene Robbins has joined the staff of Belle Glade Memorial Hospital, Belle Glade, Fla., as medical records librarian.

Charles E. Neal has been appointed director of personnel at St. Mary's Hospital, Cincinnati, replacing **Helene F. Henke,** who resigned. Mr. Neal, who had been with the personnel divisions of several companies, expects to graduate in June from the Salmon P. Chase College of Law and Commerce.

Owen K. Stephens has been appointed business administrator of Illinois State Hospital, Chicago. He was business manager of the state hospital, Elgin, Ill. At the same time, **Alfred E. Riley** was appointed business administrator of the state hospital, Jacksonville, Ill. He was formerly director of a Chicago medical employment service.

Beatrice S. Miller, director of nurses at Indianapolis General Hospital, Indianapolis, has been appointed direc-



STOP "HOSPITAL STAPH" WITH ALBAMYCIN*

Antibiotic-resistant strains of Staphylococcus are meeting their match in Albamycin. Because Albamycin shows no cross resistance with any commonly used antibiotic, it is dramatically effective against unyielding staphylococcal pneumonia or superinfections of pneumococcal pneumonia.

Whether resistant staph is known or suspected, *Albamycin is indicated.*

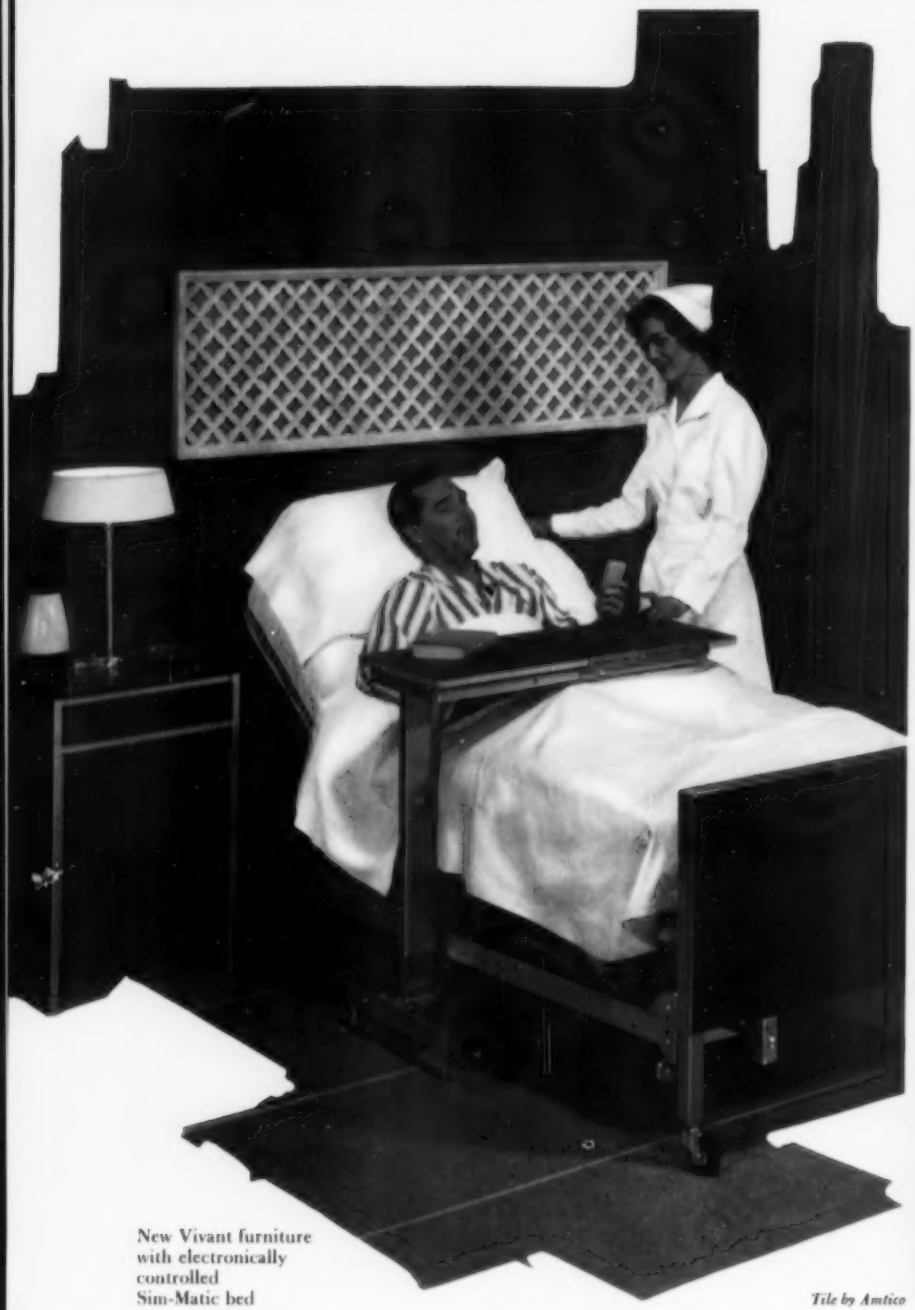
ADMINISTRATION AND DOSAGE: The dosage for adults is 500 mg. Albamycin administered intramuscularly or intravenously every 12 hours. As soon as the patient's condition permits, parenteral Albamycin should be replaced with oral Albamycin therapy.

SUPPLIED: Available as 250 mg. capsules; syrup containing 125 mg. Albamycin per 5 cc.; and in the 500 mg. Mix-O-Vial.†

The Upjohn Company, Kalamazoo, Michigan

Upjohn

*TRADEMARK, REG. U. S. PAT. OFF.—
THE UPJOHN BRAND OF CRYSTALLINE NOVOBIOCIN SODIUM
†TRADEMARK, REG. U. S. PAT. OFF.



New Vivant furniture with electronically controlled Sim-Matic bed

Tile by Amtico

Now the light-hearted look: VIVANT by Simmons

Here's furniture that puts new cheer and friendliness into any patient room! New Simmons Vivant cabinets and chests glow with the warmth of wood-grained Fiberesin phenolic laminate—beautiful to the sight and to the touch. Gracefully simple in design, Vivant has a fresh, modern look that will wear well for years to come. All Simmons hospital beds can be Vivant-paneled—and, to complete the effect, there is a new Simmons high-backed hospital chair with an ottoman.

Light-hearted in looks, Vivant is carefree in maintenance. Fiberesin tops, fronts and sides are immune to scratching, bumps or knocks...can't be discolored by wet objects or marred by cigarettes. All welded steel construction won't warp or sag. Let Vivant add new attractiveness to your patient rooms...the price is surprisingly modest!

DISPLAY ROOMS: Chicago • New York • Atlanta
Columbus • Dallas • San Francisco • Los Angeles

Merchandise Mart • Chicago 54, Illinois

SIMMONS COMPANY
CONTRACT DIVISION

tor of the school of nursing and nursing services at Sinai Hospital, Baltimore. She succeeds **Winnie A. Coxe,** who is retiring after 16 years of service.

Audrey Rolfe has been named director of nursing at Municipal Hospital, Port St. Joe, Fla. She was recently employed as head nurse at Bay Memorial Hospital, Panama City, Fla.

Mary Louise Evans has been appointed director of nursing at MacNeal Memorial Hospital, Berwyn, Ill. She formerly held a similar post at Community Hospital near Cleveland. She succeeds **Hettie Bell Travis,** who is retiring.

Miscellaneous

Ivan O. Harrah has been appointed personnel associate on the staff of the Hospital Council of Western Pennsylvania. He is a graduate of Marietta College and completed graduate courses in industrial engineering and psychology at North Carolina State College. Mr. Harrah was formerly associated with the Miners Memorial Hospital Association, Williamson, W. Va.

Dr. Irvin J. Cohen has been appointed assistant chief medical director for planning of the Veterans Administration. He succeeds **Dr. William W. Fellows,** who retired. Dr. Cohen has been deputy director for planning since August 1958 and previously was director of hospitals and clinics for the V.A. in Washington, D.C., for three years.

John H. Moye has been appointed executive director of Georgia Hospital Service Association, Inc., the state's Blue Cross plan. He succeeds **Sam M. Butler,** who resigned to become executive director of the Arkansas Medical and Hospital Service, Inc., Little Rock. **John M. Galloway** has been named assistant executive director of the Georgia association.

Deaths

Howard B. Hatfield, administrator of Long Beach Community Hospital, Long Beach, Calif., and president of the California Hospital Association, died March 11 at the age of 53. Mr. Hatfield, who had recently been named consultant to the California state department of public health, had been administrator of the Long Beach hospital since 1950. He held the same position at Scripps Memorial Hospital, La Jolla, Calif., from 1944 to 1947, and at San Pedro Community Hospital from 1947 to 1950. He was a member of the board of directors of the Blue Cross of Southern California, past president of the Hospital Council of Southern California, and past treasurer of the Association of Western Hospitals.

Dr. John Pleasant Fatherree, 51, for the last 12 years superintendent of South Mississippi Charity Hospital, Laurel, Miss., died February 22. He received his medical degree from Tulane University and in 1947 opened the Woman's Clinic in Laurel.

Herbert N. Morford, administrator of Riverside Hospital, Boston, since the spring of 1956, died March 7 at the age of 61. A graduate of the University of Pennsylvania and Crozer Theological Seminary, Mr. Morford spent several years in religious education and Y.M.C.A. work, entering the hospital field in 1931 as superintendent of Seaside Home and Hospital, Far Rockaway, N.Y. He also served as administrator of hospitals in Brooklyn, N.Y.; Winsted, Conn.; Baltimore; Summit, N.J., and Syracuse, N.Y. He was a fellow of the American College of Hospital Administrators.

Royal McBee is cutting hospital paper-work down to size

Up-to-the-minute reports on revenue analysis, patient-day and service-department statistics, patient billing, expense distribution. Reports that contribute markedly to better patient care. How to get them—without great cost or complexity? With the easy-to-use machines of the new Automatic Keysort System—today's most practical approach to data processing.

Automatic Keysort is today's *only* data processing system that provides for automatic creation and processing of original patient records. Speeding vital day-to-day and long-range facts essential to sound management, this unique system fits easily into your present operations . . . yet is highly flexible to future growth and expansion.

With the Automatic Keysort System, hospitals of every size can now enjoy the fast, accurate data processing that helps insure better patient care. Without restrictive, complex procedures. Without specialized personnel. And at remarkably low cost.

Your nearby Royal McBee Data Processing Representative will arrange a demonstration. Phone him, or write Royal McBee Corporation, Data Processing Division, Port Chester, New York for your copy of brochure S-442. In Canada: The McBee Company, Ltd., 179 Bartley Drive, Toronto 16.

Keysort Data Punch is located at nursing station, simultaneously imprints original records with patient information and code-notches them with statistical categories for rapid mechanical sorting into desired classifications.

Keysort Tabulating Punch internally code-punches quantities and amounts as a by-product of establishing accounting controls...then processes these proven records through basic accounting functions to the preparation of your necessary management reports.

Results are summarized direct from original records to Unit Analysis reports for greatest accuracy. Management gets the vital on-time information needed to provide better patient care.

NEW AUTOMATIC KEYSORT SYSTEM

ROYAL McBEE · *data processing division*

NEW CONCEPTS IN PRACTICAL OFFICE AUTOMATION

classified advertising

TERMS: 20¢ a word—minimum charge of $4.00 regardless of discounts. No charge for "key" number. Ten per cent discount for two or more insertions (after the first insertion) without changes of copy. Forms close 15th of month. The Modern Hospital, 919 N. Michigan Ave., Chicago 11, Ill.

POSITIONS WANTED

ADMINISTRATOR—10 years hospital experience, including x-ray and laboratory work; age 38, married; prefer western states; presently employed. Apply MW 50, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

ANESTHETIST—Certified Registered Nurse; male, seven years experience, desires opportunity to do fee-for-service anesthesia at small community hospital; excellent references. Apply MW 59, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois

ANESTHETIST—Experienced; age 61; wishes position in very small hospital, small town; not over two surgeons; no nursing required; in West Texas, Arizona, New Mexico, California or Nevada; not interested in the East or a large hospital. Apply MW 60, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

CHIEF—15 years food management experience; know diets, working take complete charge; prefer approximately 100-bed hospital; will relocate; salary $600. Contact Elgo, 2031 West Forest Lane, Anaheim, California.

CHIEF ENGINEER—Hospital plant and maintenance; available April 15th; new construction and operational experience of long standing; supervision of all trades; well recommended and reliable. Apply MW 53, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNICIAN—Qualified laboratory and X-Ray; with experience, desires position by July 1st or later. Please write with full details to MW 58, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1030

900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATOR—B.S., Business Administration; since 1945, director, 600-bed teaching hospital.

ASSISTANT ADMINISTRATOR—Master's in Hospital Administration; since completing residency in 1955, director of personnel and public relations, 275-bed hospital.

COMPTROLLER—B.S. (Major: Accounting); since 1951, comptroller and office manager, 210-bed hospital.

PATHOLOGIST—Diplomate, since 1952, associate professor pathology, university medical school; full time association, hospital laboratory department.

RADIOLOGIST—Diplomate; since 1952, director of radiology, 275 bed hospital and professor, radiology, medical school.

Our 63rd Year

WOODWARD MEDICAL PERSONNEL BUREAU

FORMERLY AGENCIES

185 N. Wabash-Chicago, Ill.

Telephone: RAndolph 6-5682

ADMINISTRATOR—MPH; 8 years, assistant director, acting director and director, large, voluntary, general hospital during which time hospital expanded to 350-beds highly regarded in hospital field; prefer hospital with teaching connections, 250-beds up; Member ACHA; age 38.

ANESTHESIOLOGIST—Passed Part I; now completing military obligations; seeks association with anesthesiologist, hospital practice; age 28.

PATHOLOGIST—Certified, PA; Board Eligible, CP; rotating internship, 1500-bed, general hospital; 3 years, Mayo fellow; surgery, pathology; 1 year, instructor, Pathology State University; 1 year, Pathology, 125-bed hospital; AOA.

RADIOLOGIST—Diplomate, diagnostic, therapeutic and isotopes; 7 years, medical officer; 2 years, private general practice; seeks radiology with accent on diagnosis, hospital practice; AOA; age 38.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Day, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATOR—Age: 40 years; 6 years assistant director, 275-bed hospital, Pennsylvania; 8 years administrator, 150-bed hospital, New York State.

COMPTROLLER—Degree; 12 years comptroller, 250-bed eastern hospital; available.

ASSISTANT ADMINISTRATOR—M.H.A. Degree, June 1959; Eastern seaboard or south preferred.

BUSINESS MANAGER—M.S. Degree; 4 years experience, chief accountant, eastern hospital.

BUSINESS MANAGER—Degree, Business Management; 5 years business manager, 105-bed midwestern hospital; prefers larger hospital.

SUPERINTENDENT—R.N.; 10 years director of education and nursing service; past 6 years superintendent 50-bed hospital, east.

EXECUTIVE HOUSEKEEPER—Age: 45 years; 2 months course in institutional housekeeping; 4 years experience 250-bed mid-western hospital.

A & G MEDICAL PERSONNEL AGENCY*
834 Second Street
Lancaster, Pennsylvania

ADMINISTRATOR—or Assistant Administrator; B.S. Degree in Psychology; graduate Air Force medical administrative school; at present administrator 180-bed Air Force Hospital and 2 years experience; commander 350-bed Air Force hospital; 28; military service terminates June 1959.

ACCOUNTANT—Male; B.S. Degree in Business Administration; at present hospital business manager.

X-RAY TECHNICIAN—Male; at present heads technical laboratory performing EEG, vascular temperature test, cardiographs, BMR, audiometric studies, cardiac catherization; phonocardiogram and bronchial spirometric recorder; desires position offering further advancement in field.

ADMINISTRATOR—Administrative residency expires June 30, 1959; B.S. Degree in Psychology, University Buffalo; graduate of Chicago School of Business Administration; Program in Hospital Administration, 1957; now serving residency in California.

EXECUTIVE HOUSEKEEPER—Excellent background hospital and hotel experience; 135-bed hospitals; 200-room hotels; desires to locate in California or Ohio.

PHYSICIAN—Female; OB-Gyn; wishes to locate Florida, California or other warm climate; 36 years; will accept salary, or association.

POSITIONS OPEN

ANESTHETIST—30-bed hospital; Board surgeon; near large town and shopping area; salary open. Apply MO 269, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETISTS—Nurse; for 220-bed community hospital; working with private group; two full time M.D.'s, four nurses, all agents and techniques; modernization program going on; two and one-half hours from Boston and New York. Write G. J. Carroll, M.D., William W. Backus Hospital, Norwich, Conn.

ANESTHETIST—Nurse; for 400-bed Joint Commission Accredited hospital; salary $490 per month, 40 hour week; many employee benefits. Apply Dr. R. Weyl, Anesthesiologist, Mount Sinai Hospital, California Avenue at 15th Place, Chicago 8, Illinois.

ANESTHETIST—Nurse; 50-bed hospital soon to add 20 more; recently added a new modern nursing home (geriatrics) in conjunction with hospital; salary commensurate with experience, full maintenance; town in rich farm lands 85 miles from Chicago, population 6,000. Write Alvan A. Sauer, Administrator, Iroquois Hospital, Watseka, Illinois.

ANESTHESIA—Nurse; opening in surgery division; basic 40 hour week; salary to $550.00 monthly; overtime pay; liberal employee benefit program includes vacation, sick pay, and holidays. Write Personnel Department, St. Joseph Mercy Hospital, 900 Woodward Ave., Pontiac, Michigan.

ANESTHETIST—Nurse; to cover surgery and obstetrics in 275-bed hospital with expansion program in process; excellent facilities and personnel policies; salary open. Call or write Personnel Director, 810 E. 27th Street, Minneapolis 7, Minnesota. Phone FEderal 2-7266.

ANESTHETISTS—Registered nurse; (two) for immediate openings in 300-bed hospital; excellent working conditions, very little call; salary open, depending on training and experience. Apply E. Glad, Chief Nurse Anesthetist, St. Johns Hospital, St. Paul 6, Minnesota.

(Continued on page 182)

classified advertising

POSITIONS OPEN

ANESTHETIST—Nurse; trained and experienced; graduate of approved nursing school with specialized training course in anesthesia; salary range $4750-$6178; paid vacation and sick leave; maintenance available for a single person. Apply Charles R. Walton, Personnel Director, New Jersey State Hospital, Trenton, New Jersey.

ANESTHETIST—Nurse; for 57-bed general hospital; details on request. Contact Administrator, Sid Peterson Memorial Hospital, Kerrville, Texas.

BACTERIOLOGIST—Male or female; interesting career opportunity with a secure future with Oakland County in Detroit Metropolitan area; salary $4800 to start with merit increases to $5200 in two years; retirement plan, social security, life insurance, hospitalization, paid vacation, sick leave, and other fringe benefits offered; must have B.S. Degree in Bacteriology. Apply at Personnel Office, Oakland County Office Building, 1 Lafayette Street, Pontiac, Michigan. FEderal 3-7151

BUSINESS MANAGER—$500 to $600; new 108-bed general hospital opening this fall; must be capable of managing office staff, handle accounts receivable and payable and have working knowledge of AHA accounting procedures; employment by June 1, 1959; complete brochure mailed to Wm. S. Nichols, P. O. Box 235, Arlington Heights, Illinois.

CLINICAL DIRECTOR—Vacancy at Crownsville State Hospital, Anne Arundel County, Md. for a qualified clinical director; incumbent will direct the medical, surgical and psychiatric treatment render to mental patients this is a challenging position in one of Maryland's largest mental hospitals; requires graduation from an accredited medical school; recent experience and training in an active teaching psychopathic hospital; OR at least six years recent experience in psychiatry including two years in a responsible administrative position; also requires certificate from American Board of Psychiatry and Neurology and a Maryland medical license; salary $12,000-14,440 (maximum in 5 years.) File applications immediately with the Commissioner of Personnel, 31 Light Street, Baltimore 2, Maryland.

DIETITIANS—A.D.A.; very desirable positions available for therapeutic supervisors in hospital division of our progressive Industrial Food Service Company; forty hour week, two week vacation, two weeks sick leave, meals furnished, group hospitalization insurance available; top salaries; responsible for complete administration of patient food service; school of nursing. Apply Director, Hospital Division, Cooper Industrial Food Services, Inc., 5875 North Lincoln Avenue, Chicago 45, Illinois.

DIETITIAN—Position being created by opening of 120-bed rehabilitation addition to Iowa Methodist Hospital; excellent opportunity for ADA registered hospital trained person; possibility of work in either therapeutic or administrative areas; good pay, liberal benefits. Apply Personnel Director, Iowa Methodist Hospital, Des Moines 14, Iowa.

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vaction; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Therapeutic; experienced desired; salary open. Apply Lourdes Hospital, 169 Riverside Drive, Binghamton, New York.

DIETITIAN—Chief of department; A.D.A. member or eligible for registration; 90-bed hospital; liberal vaction, holidays and sick allowance; salary open. Contact Emil Wieland, Administrator, Jamestown Hospital, Jamestown, North Dakota.

DIETITIAN—Chief; administer and direct dietary program; A.D.A. registered; experienced in dietary department administration; 185-bed J.C.H.A. approved general hospital with excellent facilities; approved diploma school of 150 students; excellent working conditions, personnel policies, and very attractive salary; 95% of active medical staff is board certified. Contact Byron D. Jackson Administrator, St. Luke's Hospital, Fargo, North Dakota.

DIETITIAN—Therapeutic; $5,000 beginning salary; exceptional opportunity for advancement — merit system; 503-adult bed, 72 bassinet general hospital. Apply Director of Dietetics, Aultman Hospital, Canton 10, Ohio.

DIETITIAN—Chief of department, A.D.A. member or eligible for registration; 90-bed hospital with expansion program this year; salary commensurate with training and experience. Apply Administrator, Grace Hospital, Cleveland 13, Ohio.

(Continued on page 184)

Introducing an entirely new product
from the research laboratories of Huntington . . .

DI-CROBE

GERMICIDAL CLEANER

the first successful combination of a soapless detergent and phenolic germicide!

Tests* prove

DI-CROBE IS BACTERICIDAL UNDER USE CONDITIONS • In the Official AOAC Use-dilution Test, Di-Crobe was used on surfaces, contaminated with organic matter, which duplicated actual field conditions. Di-Crobe works at a dilution of 1:80 under field conditions.

DI-CROBE KILLS RESISTANT STAPH 80/81 • Di-Crobe kills antibiotic-resistant strains of *Staphylococcus aureus*, including the world-wide virulent strain 80/81, at very high dilutions.

DI-CROBE HAS RESIDUAL BACTERICIDAL ACTION • Surfaces treated with Di-Crobe and allowed to dry at room temperature have continuing disinfectant activity.

DI-CROBE IS NON-TOXIC • Di-Crobe is diluted greatly with water before use; but, even in its undiluted form, it is relatively free of danger.

PHENOL COEFFICIENTS BY AOAC METHOD:

Staphylococcus aureus, 7
Salmonella typhosa, 5

*For detailed test data and verified results, ask for Research Bulletin, "Di-Crobe Germicidal Cleaner."

Long sought by research chemists because of two major advantages—stability of cleaning action and germicidal power, even when exposed to heavy soil, and mildness which will not harm the surface being cleaned.

There is no other product like Di-Crobe. Earlier products were harsh in cleaning action or lost their germicidal potency fast. Di-Crobe is a fine cleaner and removes soil safely and efficiently. It is free rinsing . . . keeps soil in suspension, removing it completely from the surface. A *soapless* detergent, it will not form a soap film, does not even interfere with electrical conductivity of flooring.

The germicide in Di-Crobe is a *phenolic*, recognized as the most reliable chemicals for general disinfecting in the hospital. Di-Crobe kills a broad range of microbes, including *Tubercle bacilli*, and fungi, even in the presence of organic matter. It is non-irritating and non-toxic.

The cleaning action and germicidal powers of Di-Crobe are carefully balanced so that the proper dilution for efficient cleaning is also the correct dilution for effective germ-killing power. It is thoroughly tested, proved efficient and low cost in use. This is a product you should test. Ask for our test results and a sample today.

HUNTINGTON

. . . where research leads to better products

HUNTINGTON LABORATORIES • HUNTINGTON, INDIANA • Philadelphia 35, Pennsylvania • *In Canada:* Toronto 2, Ontario

classified advertising

POSITIONS OPEN

DIETITIAN—Chief; Municipal TB Hospital, J.C.A.H. approved, excellent salary, permanent position; must be ADA member. Apply Superintendent, Wm. Roche Memorial Hospital, Toledo 14, Ohio.

DIETITIAN—Staff; therapeutic; A.D.A. member, hospital recently expanded to 450-beds, located in residential district; approved by J.C.H.A.; dietary facilities entirely new and air-conditioned; dietetic program integrated with N.L.N. approved school of nursing, affiliated with Medical Research Institute, 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

DIETITIAN—Therapeutic; A.D.A.; immediate opening; 100-bed general hospital; 5 day week, paid vacation, sick leave, special holidays; salary commensurate with qualifications. Contact Dietitian, Grace Hospital, Richmond 20, Virginia.

DIETITIANS—Staff; 2; Capitol City's largest and newest hospital; 290-adult beds; opened 1951; centralized food service, selective menu; ADA preferred; no teaching required; $4,000 starting salary range; liberal personnel policies. Apply Director of Dietetics, Charleston Memorial Hospital, 3200 Noyes Avenue, Charleston 4, West Virginia.

DIETITIAN—For modern 65-bed general hospital 20 miles north of Winnipeg, Manitoba; excellent working conditions, annual leave etc., salary open to negotiation. Apply to F. D. Butler, Administrator, Selkirk General Hospital, Selkirk, Manitoba.

ADMINISTRATIVE SUPERVISOR OF NURSING SERVICE—270-bed hospital; minimum requirements: B.S. degree in Nursing; experience as supervisor preferred; salary commensurate with degree and experience; school of nursing affiliated with community college. Write Mrs. Isabel Christiana, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York. Phone GLobe 2-3000. Ext. 241.

DIRECTOR NURSING SERVICE—$500 to $600; must have College Degree with successful background of supervisory experience; permanent position new 108-bed general hospital; employment July 1, 1959; hospital opening October 1, 1959; give full details in letter to Wm. S. Nichols, P. O. Box 235, Arlington Heights, Illinois.

DIRECTOR OF NURSING—Unusual opportunity for nurse who is presently serving as supervisor, assistant director or director to conduct reorganization program and plan for new hospital; salary negotiable with attractive increases according to performance; exceptional opportunity for advancement in the field; would consider person wishing to make this position a stepping stone to similar position in larger hospital; university facilities available for advance courses; interview expenses paid. Write Bethesda Hospital, Hornell, New York.

DIRECTOR OF NURSING SERVICE—For a 210-bed hospital located in the heart of America; Master's degree or equivalent in experience and education required; salary commensurate with background. Write or call Personnel Director, Sioux Valley Hospital, 1123 South Euclid, Sioux Falls, South Dakota, for full information.

ASSISTANT DIRECTOR OF NURSING SERVICES—175-bed tuberculosis hospital; 40 hour week social security; 6 paid holidays; 12 paid sick leave and vacation days; six room partially furnished house for either single or married person. Write Director Nurses, Sixth District Tuberculosis Hospital, 800 St. Anthony Street, Mobile, Alabama.

DIRECTOR—Occupational Therapy; State mental hospital, liberal employee benefits; housing facilities available; must be registered; starting salary $6366; $318 yearly increments Apply John E. Ellingham, Personnel Director, Ancora State Hospital, Hammonton, New Jersey. Phone LOgan 1-1700

DIRECTOR OF VOLUNTEERS—500-bed voluntary general hospital close to New York City; established program; excellent working conditions; give age, qualifications, experience. Apply MO 267, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

EDUCATIONAL DIRECTOR — School of Nursing; 3 year diploma program; 300-bed hospital; student body of 100; B.S. in Nursing Education required with experience; salary commensurate with qualifications; hour and half from Baltimore and Washington; challenging opportunity. Apply Director of Nursing, Washington County Hospital, Hagerstown, Maryland.

INSTRUCTOR—Medical-surgical and nursing arts; 225-bed hospital; N.L.N. provisionally accredited school of nursing, 100 students; B.S. and teaching experience desirable; liberal personnel policies; salary open. Apply to Director of Nursing Education, Allen Memorial Hospital, Waterloo, Iowa.

classified advertising

POSITIONS OPEN

INSTRUCTORS—Clinical in medical-surgical nursing and obstetrical nursing; 3 year diploma program; 300-bed hospital; student body of 100; B.S. in Nursing Education required; salary open; hour and half from Baltimore and Washington. Apply Director of Nursing, Washington County Hospital, Hagerstown, Maryland.

INSTRUCTORS—Clinical; needed in following categories; to coordinate student learning experience in medical and surgical nursing; to teach operating room technique; 90 student, 3 year diploma program affiliated with community college; minimum requirements; B.S. degree in Nursing Education, Masters preferred; experience as clinical instructor required; salary commensurate with degree and experience. Write Mrs. Isabel Christiana, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York. Phone GLobe 2-3000. Ext. 241.

LAUNDRY MANAGER—340 bed hospital; salary open, experience necessary. Contact Raymond Clark, Assistant Administrator, Robert Packer Hospital, Sayre, Pennsylvania.

LIBRARIAN—Assistant medical record; 300-bed hospital; salary commensurate with those in area. Apply Administrator, St. Joseph's Infirmary, 265 Ivy Street, N.E., Atlanta 3, Georgia.

LIBRARIAN—Medical records; for 58-bed general hospital; to be in charge of the medical records library; desirable personnel policies and starting salary; located in a resort city on the shores of Lake Michigan. Write or call collect: Ralph W. Tarr, Administrator, Grand Haven Municipal Hospital, Grand Haven, Michigan.

LIBRARIAN—Medical Records; State mental hospital; liberal employee benefits; starting $4104; $205 yearly increments; requirements college graduate; or, 2 years college plus training; or, graduate from nursing school plus training. Apply Personnel Office, Ancora State Hospital, Hammonton, New Jersey. LOgan 1-1700.

LIBRARIAN — Medical records; chief librarian position available in a friendly, progressive, and accredited hospital organization; over 300-beds and bassinets; excellent personnel policies and benefits; salary is open and reviewed periodically — no ceiling; an opportunity to work and live in vacationland Wisconsin; we will share moving expenses with you. Write Personnel Director, Mount Sinai Hospital, 908 North 12th Street, Milwaukee 3, Wisconsin.

MEDICAL SOCIAL WORKER—For large progressive health department, situated adjacent to Washington, D. C.; modern, air-conditioned offices, challenging position, opportunity to work closely with a variety of professional personnel; Masters Degree in Social Work and experience required; salary $5350 to $6420. Apply Murray Grant, M.D., Prince Georges County Health Department, Cheverly, Maryland.

MISCELLANEOUS — Openings in large modern general hospital, Southern Metropolitan City, for; registered physical therapist, nurse anesthetists, A.D.A. dietitians, pharmacist, medical technologists and nursing education instructors; progressive personnel policies, excellent working conditions; salary based on preparation and experience. Address MO 265, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS — INSTRUCTORS — Diploma program in 120-bed hospital school in central New York State, 35-50 students. (a) Obstetrical Nursing; responsible for formal and clinical teaching in maternity and newborn care; B.S. degree required; salary $4500 with benefits. (b) Science; responsible for teaching biological and physical sciences; B.S. with major in sciences; Masters preferred; salary $500 with benefits. Write MO 268, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS—Clinical Instructor in Orthopedics and Pediatrics; Nursing Arts Instructor; and Instructor in Medical and Surgical Diseases with related subjects; Bachelor's degree in Nursing Education and some experience in teaching desirable; 180-bed hospital; diploma school, one class admitted yearly; liberal personnel policies, starting salary $5,400 per year with increases for 2 years. Apply Director of Nursing, St. Luke's Hospital, Marquette, Michigan.

MISCELLANEOUS—Operating room supervisor; Operating room general duty nurse for 110-bed modern hospital; excellent personnel policies. Apply Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick, Canada.

NURSES—Registered; responsible positions open; beginning salary $270 month; recently constructed 35-bed general hospital located only 3 hours from gulf coast. Apply Administrator, Jackson Hospital, Jackson, Alabama.

(Continued on page 186)

classified advertising

POSITIONS OPEN

NURSES—Operating room; The new Palo Alto-Stanford University Medical Center; $325 to $361 per month; $20 shift premium for 3-11 & 11-7; salary increase July 1; vacation 2 to 4 weeks, retirement program, social security, hospitalization insurance, 40 hour week; rotating shift. Apply Director, Department of Operating Rooms, Palo Alto-Stanford University Medical Center, Palo Alto, California.

NURSES—Staff; The new Palo Alto-Stanford University Medical Center; $325 to $361 per month plus $20 shift premium for 3-11 & 11-7 salary increase July 1; vacation 2 to 4 weeks, retirement program, orientation program, social security, hospitalization insurance, sick benefits, 40 hour week. Apply Director, Nursing Department, Palo Alto-Stanford University Medical Center, Palo Alto, California.

NURSES—Licensed vocational; The new Palo Alto-Stanford University Medical Center; $275 to $308 per month plus $10 premium for 3-11 & 11-7; salary increase July 1; vacation 2 to 4 weeks, retirement program, orientation program, social security, hospitalization insurance, sick benefits, 40 hour week. Apply Director, Nursing Department, Palo Alto-Stanford University Medical Center, Palo Alto, California.

NURSES—Psychiatric head and assistant heads; positions available in newly established psychiatric department of modern JCAH accredited hospital; salary depends on preparation and experience; annual increments, liberal personnel benefits; 5 day, 40 hour week; must be eligible for California registration. Write stating full qualifications in first letter, to Dorothy Deeth, Director of Nursing, Saint Francis Memorial Hospital, 900 Hyde Street, San Francisco 9, California.

NURSES—Registered; general duty and operating room; modern 74-bed District Hospital, midway between San Francisco and Los Angeles, California; starting salary $325.00 per month, 5 day week. Contact Administrator, Tulare District Hospital, Tulare, California.

NURSE—Registered; for night duty in small 29-bed hospital in congenial town; beginning staff salary $300 per month. Apply St. Joseph Hospital, Cheyenne Wells, Colorado.

NURSES—Staff; positions in all clinical areas including psychiatry and respiratory center in new, 800-bed, air-conditioned hospital; 40 hour week; 3 weeks vacation annually; sick leave; beginning salary $275 monthly; periodic increments; opportunity for college study through bachelor's degree program. Write Director of Nursing Service Eugene Talmadge Memorial Hospital, Medical College of Georgia, Augusta, Georgia.

NURSES—General duty; wanted for summer months June 1st through September; 58-bed fully approved general hospital; spend your summer in Bar Harbor gateway to Acadia National Park; enjoy the cool sea breezes away from the summer heat. Write for details. Mt. Desert Island Hospital, Bar Harbor, Maine.

(Continued on page 188)

4 REASONS WHY STAINLESS **STERISHARPS** GIVE YOUR HOSPITAL LOWEST COST-IN-USE

1. SteriSharps give longer life per blade than carbon steel. The reason: SteriSharps are made from a unique alloy of extremely hard stainless steel that holds a sharp cutting edge longer.

2. SteriSharps eliminate blade waste. Unused blades are returned to stock—*not discarded like carbon steel blades*. For only SteriSharps can be autoclaved in or out of the package.

3. SteriSharps come to you ready for use, ultrasonically cleaned and sterilized. Unlike carbon steel blades, SteriSharps are *totally* rustproof.

4. SteriSharps reduce annual blade consumption, thus helping you to cut down over-all hospital expenditure for blades. In addition, SteriSharps eliminate the cost of jars, racks and chemical solutions.

Why pay more for old-fashioned carbon steel blades? Order SteriSharps for lower blade cost plus improved technique.

A·S·R STERISHARPS —the first sterile, stainless steel surgical blade

HOSPITAL DIVISION
A·S·R PRODUCTS CORPORATION
380 MADISON AVE., N. Y. 17, N. Y.

PRECISION A·S·R PRODUCTS

IN CANADA
A·S·R HOSPITAL DIVISION
2055 DESJARDINS AVE.
MONTREAL, CANADA

classified advertising

POSITIONS OPEN

NURSES—Registered; modern 98-bed hospital in Central Michigan; excellent salary and fringe benefit program; nurses residence available. Apply Clinton Memorial Hospital, St. Johns, Michigan.

NURSES—Staff; (3) fifty bed hospital, small community near St. Louis; prevailing salary, paid vacation, paid sick leave, expanding facilities. Address replies to Mr. Robert E. Harper, Jr., Administrator, Lincoln County Memorial Hospital, Troy, Missouri.

NURSES—Registered; for general duty; 76-bed hospital; salary $260 & $15 3-11, $20 11-7 per month. $5 per month increase after 6 months service; 40 hour week, 2 weeks vacation and holidays with pay after 1 year; nice college town. Apply Director of Nursing Service, Jamestown Hospital, Jamestown, North Dakota.

NURSES—General duty registered; 30-bed general hospital. Write Director of Nurses, Blue Mountain General Hospital, Prairie City, Oregon.

NURSES—Registered general duty; 100-beds; good bedside nursing required, 40 hour week, rotating duties; excellent personnel policies; you arrange for Rhode Island State Registration. Apply Nurse Director, Jane Brown Memorial Hospital, Providence 2, Rhode Island.

NURSES—Registered; for 50-bed general hospital; approximately 7,000 population; 48 hour week, 2 weeks paid vacation after one year; sick leave, holidays, liberal personnel policies; nurses residence available; starting salary $325 a month and full maintenance. Write Administrator, Coon Memorial Hospital, Dalhart, Texas.

NURSES—Graduate; $4188 to $7032.* For Washington State's Mental Health Program; Here is your opportunity to participate in one of the most progressive and dynamic mental health treatment programs in the country; choose your location in the state so bountifully endowed with scenic grandeur, mild climate and tremendous opportunities; no psychiatric experience necessary for graduate nurses in the entering level; 10 paid holidays, annual and sick leave, promotion by merit and an employee's retirement plan, are only a few of the attractions offered by these positions. For further information and applications, contact: Washington State Personnel Board, 212 General Administration Building, Olympia, Washington. (*Starting salaries dependent upon position and experience.)

NURSES—Registered; 170-bed general hospital; openings in operating room, delivery room and staff positions; starting base salary $300 per month; ideal climate, convenient recreational facilities year round. Apply Director of Nurses, Yakima Valley Memorial Hospital, Yakima, Washington.

NURSES—Registered; for general duty and special departments; new modern 150-bed hospital; starting salary $235, 5 day week, 8 hour day, 21 days vacation, 8 statutory

(Continued on page 190)

'Round-the-clock dependability

COMPLETE LINE. Choice of gleaming stainless steel or lustrous, baked-on white enamel exteriors. One, two, three or four cavity models. Capacities: Remote models—from 38.2 to 76.7 cu. ft. Self-contained: from 18 to 72.9 cu. ft. Storage Freezers available with complete automatic defrost system.

TYLER

Reach-In Refrigerators and Storage Freezers

Year after year, Tyler Reach-In Refrigerators and Storage Freezers provide food service operators with dependable, uninterrupted refrigeration performance. Tyler offers more uniform temperatures that keep foods looking better, longer. You save money with lower operating and maintenance costs. And the many built-in conveniences you get with this Advanced Design line help improve and speed up service . . . increase the overall efficiency of your operation. The Tyler line is complete with a size and model to fit your specific needs. See your Tyler Dealer or send coupon below for details.

You get more — made better — when you go Tyler!

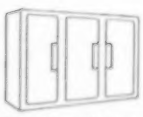
▷ New-design, patent-applied-for, adjustable, full length pan and tray shelf-supports. No tipping ▷ Tyler extra-heavy-duty mullion blower coiling assures proper temperature throughout ▷ Patterned stainless steel shield protects breaker strip ▷ Heavy-duty-type fan for positive No-Block air circulation ▷ Choice of white, baked-on enamel; stainless steel or aluminum interiors ▷ Adjustable temperature control ▷ Famed Tyler welded-steel construction.

NEW REACH-THRU REFRIGERATORS. Stainless steel or baked-on white enamel exteriors. Two, three, or four cavity models. Capacities: Remote models—from 38.2 to 76.7 cu. ft.; Self-contained models—from 34.5 to 72.9 cu. ft.

Big TYLER line meets every food service need!

Slide-Door Refrigerators

Beverage Coolers



Sectional Storage Freezers

Walk-In Storage Freezers

Walk-In Storage Coolers

TYLER

PIONEER of important improvements

TYLER REFRIGERATION CORP., Niles, Mich.
Canada: Tyler Refrigerators, 732 Spadina Ave., Toronto, Ont.
(Export: Tyler Refrigeration International, C. A., Apartado Postal 9262, Caracas, Venezuela, S. Amer.)

TYLER gives you more!

Send coupon today

Tyler Refrigeration Corporation, Dept. MH-5 Niles, Michigan
☐ Send details on NEW TYLER LINE of Reach-Ins and Storage Freezers. Also send complete information on Tyler ☐ Slide-Door Refrigerators ☐ Walk-In Coolers ☐ Walk-In Freezers ☐ Beverage Coolers and Dispensers ☐ Sectional Reach-In Storage Freezers.

NAME _____

ADDRESS _____

classified advertising

POSITIONS OPEN

holidays and pension plan. Apply Director of Nursing, St. Joseph's Hospital, Brantford Ontario, Canada.

PHARMACIST—Registered; male or female; for 400-bed general hospital in Hawaii; liberal personnel policies, hospitalization coverage, group life insurance, retirement, 40 hour week; state salary desired. Write Personnel Director, The Queen's Hospital, P. O. Box 861, Honolulu, Hawaii.

PHYSICAL THERAPIST—Staff; salary commensurate with training and experience; 340-bed hospital. Contact Raymond Clark, Assistant Administrator, Robert Packer Hospital, Sayre, Pennsylvania.

SUPERINTENDENT—Assistant; east; responsible for direction of non-professional departments; must have sound hospital accounting background with experience in credit and collections; liberal vacation, sick leave, and fringe benefits; salary open. Apply to MO 261, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERVISOR-INSTRUCTOR — Operating room; 209-bed general hospital; NLN fully accredited school of nursing; 90 students; 40 hour week; special clinical preparation in operating room supervision; salary open, liberal personnel policies. Apply Director of Nursing, Middlesex Memorial Hospital, Middletown, Connecticut.

SUPERVISOR—Operating room; 126-bed hospital, southern New Hampshire; administrative supervisor with operating room experience and preparation; attractive salary, liberal personnel policies. Apply Director of Nursing, Elliot Community Hospital, Keene, New Hampshire.

SUPERVISOR—Operating room; JCAH accredited 216-bed general hospital with NLN fully accredited school of nursing; completely new operating room suite under construction; special preparation and experience in operating room supervision desired; salary commensurate with qualifications. Apply to Director of Nursing, St. Joseph's Hospital, Elmira, New York.

SUPERVISOR—Operating room; 79-bed voluntary hospital with building program; satisfactory supervisory experience needed; salary commensurate with qualifications; paid vacation, sick leave, 8 holidays; North Shore Long Island 60 miles east New York City. Apply Administrator, John T. Mather Memorial Hospital, Port Jefferson, New York.

TECHNOLOGIST—Medical; to supervise clinical laboratory in 300-bed hospital; ASCP registered; experience; prefer Bachelor degree; 40 hour week with minimum call; liberal benefits, salary open. Apply to Hospital Administrator, St. Johns Hospital, St. Paul 6, Minnesota.

TECHNOLOGIST — Registered medical; A.S.C.P.; male or female; required immediately for an 85-bed, rural J.C.A.H. approved general hospital, situated midway between Pittsburgh and Harrisburg; famous resort area; salary open. Apply Memorial Hospital of Bedford County, Bedford, Pennsylvania, or Telephone the Director BEdford 655.

TECHNICIAN — Laboratory; Brightlook Hospital, St. Johnsbury, Vermont; 52-bed, accredited general hospital; laboratory in charge of a registered medical technologist and part time pathologist; salary dependent on qualification. Communicate with Ralph H. Ross, Administrator.

Our 63rd Year

WOODWARD MEDICAL PERSONNEL BUREAU

FORMERLY AZNOES

185 N. Wabash-Chicago, Ill.

Telephone: RAndolph 6-5682

ADMINISTRATORS — (a) Medical Director; very large, fully-approved, county hospital; about $20,000; West coast. (b) Report directly to medical director; very large, fully-approved hospital, affiliated with three universities; $12,000,000 building program; about $13,000; east. (c) 200-beds; building now; should be ACHA or equivalent; employ now; $15-18,000; midwest (d) 50-bed, private hospital; $10-15,000; excellent location, California. (e) New 90 bed, private, general hospital requires one strong on profitable operation about $12,000 plus increasing % of net and other excellent benefits; should result in very liberal income; coast resort area; southeast. (f) 175-bed, voluntary, general, JCAH hospital; duties also include assisting completion-separate new 150-bed, general hospital; substantial; California. (g) Replace one retiring 165-bed, general, voluntary hospital; salary open; university city, mideast. (h) 80-bed hospital, adding new wing; $10,000 or more; resort area; southeast. (i) Assistant administrator; 150-bed, city, general hospital; $5,400-$7,200; south. (j) Assistant superintendent of hospitals & institutions; large university and college city; New England. (k) Assistant administrator, under Member ACHA; 250-bed fully-approved general hospital; university city 200,000, west.

ADMINISTRATIVE POSTS—(1) Accountant; new post; one who enjoys research and conducting studies; serve 35 hospitals; to $10,000 start; large university city, midwest. (m) Comptroller; 400-bed, general hospital; $8,000, possibly more; New York State. (n) 450-bed, fully-approved hospital; prefer MHA with personnel-public relations background; east.

The Medical Bureau

M. BURNDICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS—(a) Administrator, 8 to 10 years experience; hospital eventually will have 400-beds; $10,000-$12,000 to start; Florida. (b) Administrator, 90-bed hospital being built in new, planned community, south; will be increased to 150-beds; $9,000-$12,000. (c) Administrator, 70-bed general hospital, city of 10,000, northwest, 40 miles from ocean. (d) Nurse, manage new 50-bed hospital, large eastern seaport city near exclusive resorts; maintenance provided; top salary. (e) Assistant administrator, 3 related hospitals, preferably 35 - 40 with degree in hospital administration and several years experience; minimum salary $12,000; west. (f) Assistant administrator, 200-bed hospital; residential suburb, large city, Pennsylvania; opportunity for advancement. (g) Assistant administrator, 325-bed hospital; preferably with degree in hospital administration; salary open; western New York. (h) Personnel-public relations director, man or woman, with hospital experience and preferably degree in hospital administration; 500-bed hospital, east. (i) Assistant administrator, with public relations experience; $8,500; middlewest. (j) Assistant administrator, 350-bed general hospital, south;

(Continued on page 193)

KNOCKS OUT NOXIOUS ODORS! MURDERS MICRO-ORGANISMS!

Meet N-DIT, the new Holcomb sanitizing champ' with a "powerhouse" *one-two* punch:

. . . potent, full-range disinfecting power that brings sudden death to a broad range of bacteria including *Staph.*

. . . positive chemical action that destroys odors at their source—doesn't just cover them up with a different odor.

. . . plus remarkable cleaning powers. Holcomb N-DIT Concentrate is a liquid synthetic detergent that mixes instantly and completely in hot, cold, soft or hard water. Has high sudsing, complete dirt penetration and suspension, and free rinsing properties.

N-DIT is used any place, on anything, where water is used. It is concentrated to save money and a little goes a long way.

N-DIT is an all-new formulation, built from the test tube up, in the Holcomb research laboratories —largest, most complete of its kind, anywhere.

For effective disinfecting, deodorizing and cleaning —in one easy, economical operation, try Holcomb's N-DIT. Your Holcombman will be glad to demonstrate it for you.

J. I. HOLCOMB MFG. CO., INC. · 1601 BARTH AVENUE · INDIANAPOLIS, INDIANA
Hackensack · Dallas · Los Angeles · Toronto

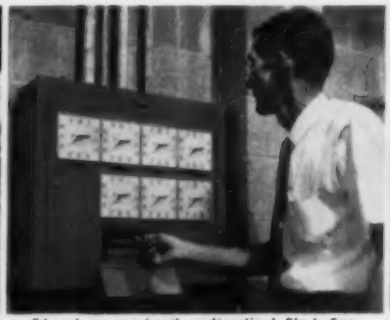
at Grady Memorial Hospital they know...

Only Edwards manufactures **all** the signaling systems required by modern hospitals

Edwards specializes in signaling systems for hospitals, manufacturing everything from protective annunciators for vital power systems to pharmacy intruder alarms. Some of the typical Edwards installations shown below at Grady Memorial Hospital in Atlanta, will give you an idea of the wide range of Edwards products for control, communication and protection.

Why not see how Edwards systems can make your hospital safer, more convenient in routine, most efficient in operation. Remember, Edwards technical representatives have been helping hospitals solve their signaling problems since electrical systems were introduced. Write Edwards, Dept. MH-5, or call the nearby Edwards sales office. There's never any obligation—so why not call today.

Maintenance Engineer inspecting Edwards Power Distribution Annunciator monitoring vital electrical systems.

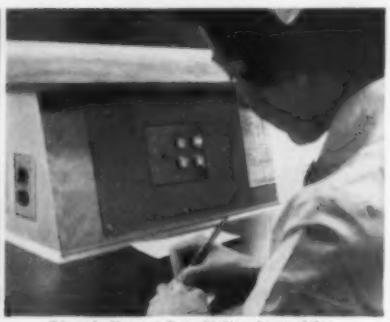


Edwards seven-circuit sectionalized Clock Control Board with Automatic Reset Control.

Edwards clock installation in lobby.

Edwards patient bedside signal station.

Edwards Nurses' Call Master Station Annunciator —has emergency lamps and bell plus buzzers for standard operation. Edwards clocks, regular and emergency dome lamps in background.



Edwards Nurses' Duty Station Annunciator

500 name Edwards In & Out Register.

All photos taken at Grady Memorial Hospital, Atlanta, Georgia

EDWARDS

Specialists in signaling since 1872

CONTROL • COMMUNICATION • PROTECTION

Edwards Company, Inc., Norwalk, Connecticut (In Canada: Edwards of Canada, Ltd., Owen Sound, Ontario)

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

duties principally personnel and purchasing departments. MH5-1

ACCOUNTANTS—(a) Controller, 200-bed general hospital, university and college city, California; $10,000. (b) Controller, foreign university; capable taking over financial control; familiar budget control, cost accounting; must have mature judgment. (c) Controller, 400-bed general hospital, midwest; must have degree, with major in accounting, plus experience in budget development and fiscal control. MH5-2

ANESTHETISTS—(a) Join staff of 3, 100-bed hospital near San Francisco; to $7200. (b) Alaska; small hospital, ocean city near mountains; $7000. (c) OB, 250-bed hospital; near winter-summer resorts, Florida; $5000-$6000. (d) Share service 200-bed hospital with male anesthetist; excellent financial opportunity; Upper Michigan resort. MH5-3

DIETITIANS—(a) Develop, test recipes for national food concern promotional material; east. (b) Chief, small general hospital near Florida resorts; good salary. (c) Chief, 200-bed hospital; Philadelphia vicinity; $6500. MH5-4

DIRECTORS OF NURSING—(a) Director, service school, 350-bed hospital, Michigan; good opportunity reorganize; building program; $8,000. (b) Dean, Collegiate School of Nursing; prefer Ph.D; well coordinated program excellent clinical facilities; top salary. (c) Director of Nursing, 400-bed hospital; leading east coast city, $7000-$10,000. MH5-5

EXECUTIVE HOUSEKEEPER—(a) 300-bed modern hospital; beautiful Pennsylvania hill country; top salary. MH5-6

EXECUTIVE PERSONNEL—(a) Engineer, charge plant management, maintenance, construction; building program; $10,000-$12,000. (b) Food Service Director, large eastern hospital; must have restaurant experience; $8000. MH5-7

FACULTY POSTS—(a) Fundamentals of nursing; collegiate nursing program; co-educational school, California; $6300. (b) Head diploma school, 100 students from 3 local hospitals; southwestern medical center; $6000-$8000. MH5-8

RECORD LIBRARIANS—(a) Reorganize and direct department, 150-bed modern hospital, California; salary commensurate ability. (b) Chief, renowned medical research clinic; Great Lakes; $6000 up. MH5-9

SUPERVISORS—(a) O.R. supervisor; outstanding opportunity, administrative person with experience; 13-room suite; $6000 up; near New York City. (b) OB, busy maternity department; renowned Chicago hospital; $5000-$6000 up. (c) Foreign assignment; supervise nursing activities 200-bed hospital for U. S. oil company employees; $8000-$10,000; must have B.S. experience. MH5-10

A & G MEDICAL PERSONNEL AGENCY
834 Second Street
Lancaster, Pennsylvania

NURSES—Administrative; (a) Educational director, clinical instructors in M/S nursing and OB nursing; 300-beds, salary open; Maryland. (b) Educational director and nursing arts instructor, 300-beds, salary open; Virginia. (c) Director of nurses, 135-beds with inc. 200, salary open; Pennsylvania. (d) Clinical instructor; 50-bed specialty hospital, salary open; New Hampshire. (f) Director of nursing service and school nursing, 168-beds, salary $6,000 range; Pennsylvania. (g) Nursing arts instructor, medical surgical clinical instructor, 115-beds, salary open; Midwest.

NURSES—Supervisors; (a) OB; 115-beds, salary open, midwest. (b) Operating room; 140-beds, salary open; west. (c) OB; 250-beds, salary open; Ohio. (d) Operating room; 57-beds, salary open; midwest. (e) Operating room; new medical center, salary open; east. (f) Operating room; 140-beds, salary open; midwest; male or female.

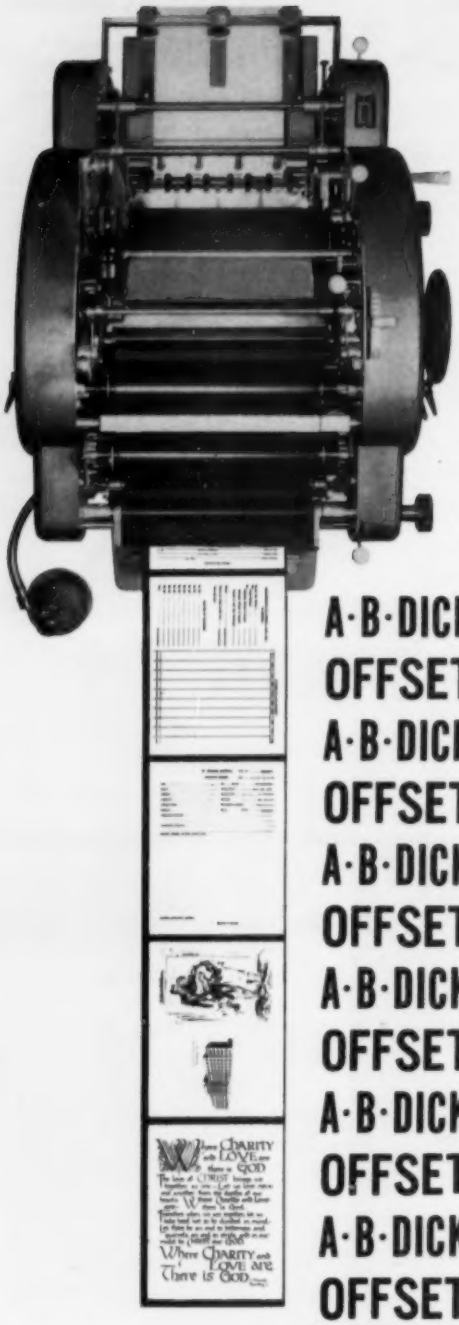
NURSES—Anesthetists; (a) 2 openings, 669-beds and expanding, salary to $648; midwest. (b) 50-beds, salary open; Arizona.

NURSES—Staff and OR nurses; hospital in West Virginia to affiliate with School of Medicine. (b) School nurse; $425 month, plus car allowance; west. (c) Other staff positions available.

HOUSE PHYSICIAN—For modern well equipped, 130-bed Pennsylvania hospital, salary to $10,000; Pennsylvania license or eligible; also for hospital in New York State, salary open.

PATHOLOGIST—Chicago area, 100-beds and expanding; salary open.

(Continued on page 195)



A·B·DICK
OFFSET
A·B·DICK
OFFSET
A·B·DICK
OFFSET
A·B·DICK
OFFSET
A·B·DICK
OFFSET
A·B·DICK
OFFSET
A·B·DICK
OFFSET
A·B·DICK
OFFSET

Cut forms and inventory costs by 40% or more. Produce letterheads, forms, envelopes, and bulletins . . . in black or brilliant colors.

All A. B. Dick offset duplicators are equipped with amazing new Aquamatic control that insures precise ink-water balance. Perfect copy quality from start to finish . . . no time-consuming make-ready. Blanket and impression cylinders adjust automatically for different master thicknesses and paper weights. Variable speeds up to 9,000 copies per hour.

St. Francis Hospital in Milwaukee, Wisconsin, cut 40% from their forms costs when they started using an A. B. Dick offset duplicator. They realize additional savings by keeping inventories low to minimize scrap loss when form changes occur. Mail the coupon at the right for a free copy of St. Francis Hospital's factual report on how they achieved these savings. Or see your A. B. Dick Company distributor, listed in the yellow pages, for a copy or a free demonstration.

A·B·DICK®

Achievement through Innovation

classified advertising

POSITIONS OPEN

A & G MEDICAL—Continued

PHARMACIST—(a) 50-beds, large group practice with expansion program; future very good, salary to $6,500, male; Florida. (b) Assistant, 300-beds, air-conditioned, salary open, Maryland.

PHYSICAL THERAPIST—81-beds, well equipped, new and modern, salary open; west.

PHYSICIAN ANESTHETIST—Board certified, active staff privileges, 183-beds, salary open; Virginia.

MEDICAL TECHNOLOGISTS—(a) Immediate opening, hospital to affiliate with School of Medicine, salary open; West Virginia. (b) Chief; salary open; west. (c) 300-beds, salary open; Ohio. (d) 2 openings, 200-beds, $400 month; Kentucky. (e) 2 openings, 90-beds, 40 hour week; $375 month; Michigan. (f) Also able do X-Ray call, $350 plus calls; Arizona.

LABORATORY TECHNICIANS—(a) 2 for 100-bed, salary open; Virginia. (b) To become chief, 120-beds, salary open; New Jersey. (c) Laboratory and X-Ray; $450 month; Florida. (d) 50-bed modern, X-Ray call extra, salary open; Arizona. (e) 85-beds, 2 openings, salary open; New York. (f) 92 beds, college town, $350 month; southwest.

DIETITIANS—(a) ADA registered; 115-beds, salary open; plan for department; midwest. (b) 72-beds, $4,000; New York. (c) Administrative and therapeutic; 400-beds, teaching institution, salary range $450; west.

FOOD MANAGER—Male; hospital buying and experience; Kentucky.

MEDICAL RECORD LIBRARIANS—(a) Chief; 10 assistants, active program, salary $5,400 to $5,800; east. (b) 100-beds, Chicago suburb; salary open. (c) 220-beds, salary open; Ohio.

Inquiries confidential. Write for details. No registration fee.

MEDICAL EMPLOYMENT SERVICE
59 East Madison Chicago 2, Ill.
ANdover 3-5663-64
Alfred E. Riley, R.N., MSHA Director

ADMINISTRATORS—(a) New hospital; excellent opportunity for qualified hospital administrator with public relation experience; salary $15,000. (b) Resort area in Florida; administrator of high caliber executive type; age: 30-45; salary $12,000 with benefits.

ASSISTANT ADMINISTRATOR — Will supervise personnel and purchasing departments and act for the administrator in his absence; salary $7,500 and up, depending upon qualification; 350-bed hospital.

FINANCE ADMINISTRATOR AND HOSPITAL ECONOMIST—Age about 30; will be attached to administrative staff; must have cost accounting education and experience; this is an excellent opportunity for the right individual; hospital in fine location.

(Continued on page 196)

classified advertising

POSITIONS OPEN

MEDICAL EMPLOYMENT—Continued

PERSONAL DIRECTOR—Must fill this position without delay; salary will be $500-600, commensurate with qualifications; hospital in beautiful location with all conveniences.

BUSINESS MANAGER—To assist administrator; new hospital; salary open; immediate employment for right individual; location ideal.

ANESTHETISTS—Five, needed at once; accredited hospitals; salary $600 and up; desirable locations.

NURSES—Director of Nurses; we have several openings, eastern and midwest locations; approved hospitals; salary $6,000 and up.

OPERATING ROOM SUPERVISOR—B.S. Degree; 150-bed hospital; salary $5,000.

MEDICAL RECORD LIBRARIAN—Four, needed to assume full responsibility of the medical records department; salary commensurate with qualifications and size of hospital.

LABORATORY TECHNICIANS — Many positions available for ASCP and non-registered; ideal locations, inviting salaries; openings for male and female technicians.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATIVE PERSONNEL — (a) Administrator; Alaska; prefer, R.N.; laboratory technician, X-ray technician, etc; $5,000 plus maintenance. (MH-2978). (b) Administrative assistant; California; qualified to serve as business manager; good potential for advancement; 225-bed teaching hospital; $7000 up. (MH-2848). (c) Assistant superintendent of hospital; east; Degree in Hospital Administration, Business Management or Accounting. to $7500. (MH-2938). (d) Administrator; middle west; 50-bed hospital fully approved. (MH-2911). (e) Assistant administrator; middle west; 250-bed hospital with large out-patient department. (MH-2937). (f) Assistant administrator; south; 350-bed hospital; supervise personnel and purchasing departments; guide and direct new projects; to $7800. (MH-2850). (g) Administrative assistant; 350-bed hospital near Boston; assist director of house services. (MH-2798). (h) Purchasing agent; east; 500-bed hospital near New York City; hospital experience. (MH-2828). (i) Director of volunteers and public relations; large teaching institution near New York City. (MH-2897). (j) Personnel and public relations director; east; new position - great potential; 500-bed general hospital. (MH-2969).

ANESTHETISTS—(a) Middle west; new 50-bed completely modern hospital; about 50 surgical procedures a month; $700. (MH-2869). (b) California; man only; 6 man

(Continued on page 198)

new **carrom** adjustable-height beds

AT NEW LOW PRICES

MANUAL ADJUSTABLE-HEIGHT

- Fingertip operation, even under heavy load
- Smooth-running, ball-bearing crank mechanism
- Single crank for easy height adjustment

ELECTRIC ADJUSTABLE-HEIGHT

- Raises, lowers, at touch of a switch
- Automatic stops at high and low positions
- Powerful, safe, heavy-duty, lubricated motor, fully protected against thermal overload
- Light, simple, clean drive mechanism

Designed and engineered for superior performance at prices you can afford to pay! These two new Carrom beds can be set up as easily as conventional beds. Indestructible ball-bearing pulleys assure smooth operation, posts are accurately machined for easy and noiseless height-adjustment. Additional quality features include corner posts that accommodate an irrigator rod and fracture frame, and heavy-duty, Trendelenberg-type spring to insure patient comfort. Birch wood end panels add a beautiful, home-like appearance. Choice of colors on end panels. Write for full details today.

a SHAMPAINE industry

Carrom industries inc.
LUDINGTON, MICHIGAN

Offers a complete line of matching fine wood furniture

classified advertising

POSITIONS OPEN

SHAY—Continued

group of physicians; 30 hour week; $500 minimum. (MH-2855). (c) Southwest resort area; progressive city of 30,000; 125-bed hospital; $500 minimum. (MH-2859). (d) Alaska; 100-bed hospital; 8 physicians on staff; $575 plus. (MH-2709). (e) Middle west; 400-bed hospital expanding to 550; new surgery will be opened soon; $600. (MH-2652).

PHARMACISTS—(a) Chief; west; University Medical Center; 5 registered pharmacists in department; some teaching of house staff and students in writing of prescriptions; to $7500. (MH-1910). (b) Chief; middle west; 225-bed teaching hospital; expansion program in progress; $7200. (MH-2064). (c) Assistant; south; near Washington, D. C. completely air-conditioned 300-bed hospital. (MH-2986).

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATOR—(a) 125-bed Ohio hospital, (b) 100-bed hospital, east. (c) Small private hospital, central state. (d) Orthopedic hospital.

ASSISTANT ADMINISTRATOR—(a) 350-bed hospital, central state. (b) 200-bed hospital, western university city. (c) Sisters' hospital, Ohio. (d) Administrative assistant; 600-bed hospital, south. (e) R.N.; Children's hospital, midwest.

COMPTROLLER—(a) 200-bed hospital, southeast Ohio. (b) 175-bed mid-western hospital. (c) 190-bed western hospital. (d) Business manager; 100-bed eastern hospital. (e) 170-bed hospital, New York State.

DIRECTOR—Housekeeping services; to $500.

DIRECTOR, NURSING EDUCATION; (a) Attractive community, east; $6500. (b) Ohio; to $7200.

DIRECTOR, NURSING SERVICE—(a) New hospital, east; 250-beds; (b) 140-bed Ohio hospital. (c) 100-bed hospital, south. (d) Large teaching hospital.

LABORATORY X-RAY TECHNICIAN—Southwest; $500.

PERSONNEL—Public relations director; (a) 350-bed eastern hospital. (b) 300-bed Ohio hospital. (c) 300-bed southern hospital.

PHARMACIST—(a) 300-bed new hospital, Ohio. $550. (b) Mid-western hospital.

(Continued on page 200)

LOWER your ANNUAL TOWEL COSTS NIBROC® HI-DRY TOWELS *are* easy on the budget—hard to top for fast drying action. Mail the coupon today for a Customer Service set of 8 Washroom Posters that will help you cut towel consumption—reduce maintenance. Check also for samples, complete information and name of nearest Nibroc dealer.

BROWN COMPANY
Towel Sales Division
150 Causeway St., Boston 14, Mass.

☐ Send me set of Posters.
☐ Send samples and complete information.

NAME _____ TITLE _____

FIRM _____

STREET _____

CITY _____ ZONE _____ STATE _____

classified advertising

PLACEMENT BUREAUS

FOR SALE

(Continued on page 202)

Illustration: Memorial Hospital, Albany, N. Y., featured in The Modern Hospital as the "Hospital of the Month" in August 1958. This 235-bed, $3.5 million hospital replaces an older building a few blocks away. Architects: Curtin and Riley, Boston. The architects subscribe to The Modern Hospital; the hospital has three subscriptions in force: one in the name of the hospital, one to the business manager, one to the chief dietitian.

hospital people want

The Modern Hospital

OF ALL THE MAGAZINES PUBLISHED for hospital administrators, their department heads and other hospital personnel, only THE MODERN HOSPITAL sells every subscription at the full published price without special inducements of any kind. This evidence of "wantedness", coupled with a long history of steadily increasing subscription sales, indicates that more and more hospital people want THE MODERN HOSPITAL—because they find it not only helpful in their work but interesting and exciting, alert and competent in its reporting of facts, ideas, opinions that make more competent the exacting, interesting and challenging business of running the nation's hospitals.

an F. W. DODGE CORPORATION publication

The Modern Hospital Publishing Co., Inc.

919 N. MICHIGAN AVENUE, CHICAGO 11, ILLINOIS

For additional information, use postcard facing Cover 3.

classified advertising

MISCELLANEOUS

ST. LUKE'S HOSPITAL
NEW BEDFORD, MASS.

POSITIONS OPEN: Female
O. R. Supervisor
Clinical Instructor
O. R. Nurses
Staff Nurses

Modern 350-bed hospital in lovely New England community near Cape Cod. Salary commensurate with education and experience. Excellent benefits. Apply Personnel Director.

SCHOOLS—SPECIAL INSTRUCTION

SCHOOL OF ANESTHESIA—Approved by the A.A.N.A. Open to registered nurses of accredited schools of nursing. Applications being accepted. For complete information write to Susan C. Prince, Director of School of Anesthesia, The Memorial Hospital, Wilmington, Delaware.

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all techniques in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

BARNES HOSPITAL: Offers an 18 month post-graduate course in Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met. Miss Helen Vos, R.N., B.S. Educational Director. Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, Barnes Hospital, St. Louis 10, Missouri.

SCHOOL—SPECIAL INSTRUCTION

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the director of Laboratories, Barnes Hospital 600 S. Kingshighway, St. Louis, Missouri.

"ANESTHESIA SCHOOL FOR NURSES. St. Joseph's Hospital, Lancaster, Pennsylvania. 18 month course AANA approved. No tuition. Stipend. Large clinical experience for students including great many endotracheal intubations. For complete details write Dr. N. Kornfield, St. Joseph's Hospital, Lancaster, Pa."

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

TOO LATE TO CLASSIFY

POSITIONS OPEN

ADMINISTRATOR—Qualified administrator for 77-bed hospital in Northern Ontario. Apply, stating qualifications, salary expected and previous experience to Mr. A. Jackel, Chairman, Board of Directors, Lady Minto Hospital, Cochrane, Ontario.

ANESTHETIST—Nurse; 50-bed modern hospital; located in the middle of the Western North Carolina Mountain tourist area; salary depends upon qualifications and experience. Apply Administrator, C. J. Harris Community Hospital, Sylva, North Carolina.

DIETITIANS—To work for food service company with operations in principal West Coast cities and Denver; formal 10 week training program followed by assignment involving full range of management activities; excellent opportunity for development and advancement; salary open. Reply to Food Service Management Division, Manning's, Inc., 901 Battery Street, San Francisco 11, Calif.

HOUSEKEEPER—Assistant; 185-bed modern hospital; to serve as full assistant in an expanding department, capable of training and instruction, 2 years hospital experience desired; liberal employee benefits; salary open. Apply to Executive Housekeeper, Mount Sinai Hospital, Hartford 12, Connecticut.

NURSES—Surgery; must be experienced; beautiful 83-bed hospital in Los Angeles suburb; excellent salary and working conditions; 5 day week. Apply Administrator, San Gabriel Valley Hospital, 115 E. Broadway, San Gabriel, California.

SURGICAL GUT | SILK | COTTON | NYLON | POLYETHYLENE | STAINLESS STEEL | ATRAUMATIC* NEEDLES—STANDARD OR PRE-CUT LENGTHS

STANDARDIZE

on safer, individually-packaged SURGILOPE SP* sterile suture strip pack

- complete line in double-envelope strip pack eliminates all storage jars and solutions . . . checks cross-contamination at the suture level!
- no broken glass to damage sutures, cut gloves and fingers, or invade operating field
- loose coil replaces reel . . . eliminates kinks, avoids excessive handling
- simple, speedy technic cuts preparation time . . . reduces waste by allowing extra sutures to be opened as needed
- boxes instead of jars means no breakage, convenient storage, easier handling

*Trademark Patent Pending

SEE THIS IMPORTANT O.R. FILM

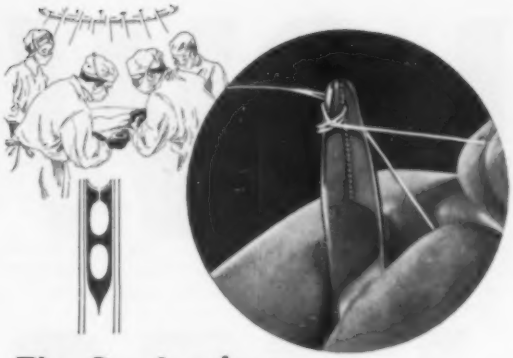
SURGILOPE SP*—A Safer Suture Dispensing Technic. Introduction by Carl Walter, M.D., F.A.C.S.
20 min., sound & color, 16 mm. Available through your Surgical Products Division representative . . . or write direct.

CYANAMID

AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
30 ROCKEFELLER PLAZA
NEW YORK, N. Y.

SALES OFFICE: DANBURY, CONNECTICUT

PRODUCERS OF DAVIS & GECK BRAND SUTURES AND VIM® BRAND HYPODERMIC SYRINGES AND NEEDLES



The Berbecker "SPRING-EYE" Needle

THE BERBECKER Spring Eye may be threaded at any point on the suture merely by forcing the suture through the slot into place. It is then held as securely as though in a solid eye.

This eye permits use of black silk or other non-absorbable sutures, as used in the Halsted technique, for stomach and other abdominal operations, where tension on the wound is excessive. One of many dependable Berbecker needles obtainable regularly at your surgical supply dealer.

Julius Berbecker & Sons, Inc., 15H E. 26 St., New York 10, N.Y.

BERBECKER SURGEONS' NEEDLES

Made in England for the Surgeons and Hospitals of America

PRINTED FORMS are more than just paper and ink!

As tools of business, your printed forms can increase the efficiency of your hospital operation, or they can add considerably to the work load of your staff and create unnecessary errors in your accounting system.

If your business forms have grown like topsy, and you would like the expert help of someone who is familiar with hospital problems and procedures, call your Shelby representative. He can show you the way to record-keeping economies and save you money on your printed forms purchases. There's no obligation.

THE SHELBY SALESBOOK COMPANY
SHELBY • OHIO

SHELBY

CONSULT TELEPHONE DIRECTORY
FOR YOUR LOCAL SHELBY REPRESENTATIVE

Visi-Shelf

can increase your present filing capacity by almost 200%!

America's First and Foremost Shelf Filing System with—

more FILING CAPACITY—
Visi-Shelf units are available with from 7 to 10 Openings High (or up to the ceiling if desired!)

more RECORD PROTECTION—
Patented, light weight Doors available on all Visi-Shelf units!

more FILING PRODUCTION—
Visi-Shelf's exclusive "Facile Guide Pull" provides more accurate filing; quicker reference!

Visi-Shelf FILING SYSTEM

OVER 4,000 VISI-SHELF INSTALLATIONS IN ALL PHASES OF AMERICAN BUSINESS SINCE ITS INTRODUCTION A FEW YEARS AGO!

Write today for free catalog and name of nearest dealer.

VISI-SHELF FILE, INC.
225 Broadway, Dept. H-5A
New York 7, N. Y.

NEW LOW PRICES

ON THE ORIGINAL FLEX-STRAW®

- Proved in a decade of hospital use.
- Extra-strength paper . . . ¼ inch diameter.
- For hot liquids, coated with high temperature resistant micro-crystalline wax.
- Hospital surveys prove FLEX-STRAWS cost less.
- Added protection plus economy!

CONTACT YOUR FLEX-STRAW DISTRIBUTOR FOR CURRENT QUOTATION

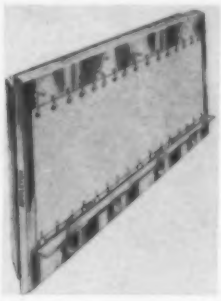
CANADIAN DISTRIBUTOR:
Ingram & Bell, Ltd.
Toronto, Montreal,
Winnipeg, Calgary,
Vancouver

FLEX-STRAW CO., Int'l.
2040 BROADWAY, SANTA MONICA, CALIF.

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 237. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Continuous Surface on Explosion-Proof Illuminators

The explosion-proof EFUX Film Illuminators are now available in two, three and



four-width models to provide as much continuous viewing surface for x-ray films as may be practical for the department. The wider film illuminators permit study of a sequence of film without separations between the sections of film, thus speeding their reading. Additional units may be added by "ganging" where more viewing surface is required.

The flush-mount Appleton Film Illuminators have built-in features for added convenience, including positioning of switches. Clear, shadowless x-ray viewing is assured by placement of the fluorescent lamp fixtures. Relamping is facilitated by the design. **Appleton Electric Co., 1701 Wellington Ave., Chicago 13.**

For more details circle #457 on mailing card.

Walls and Baseboards Protected by Splayed Base

How tile walls and baseboards are protected from damage by moving equipment is illustrated in the photograph showing Natco Splayed Base ceramic glaze Vitritile installed in a hospital corridor. Natco Ceramic Glaze Handrail, recessed into the tile

wall surface and projecting only one inch, thus saving stair space, is also shown.

Six new shapes are offered in the Splayed Base Shapes which conform with the Natco "6T" Vitritile facing tile series. The shapes are adaptable to every wall surface, including plaster, which might become chipped, scratched or otherwise defaced. It also facilitates sanitation in kitchens, laboratories, corridors and other areas. The new shapes feature a three-inch inclined projection outward from the base surface of the wall. They are available in black, dark green and brown trim shades, or in the standard Natco colors for matching or contrasting patterns. **Natco Corp., 327 Fifth Ave., Pittsburgh 22, Pa.**

For more details circle #458 on mailing card.

Ceiling-Mounted Light Is Fluorescent Room Unit

Four levels of illumination are provided in the new ceiling-mounted, three-compartment, fluorescent patient room lighting unit recently introduced. Full, bed-length illumination of surgical quality for examination or treatment; soft, general room light; high-level, visually-correct light for reading or other work, and a safety night light are included in the unit.

The Astrilite is an Amsco fixture designed to serve all lighting requirements in the patient room. The optical system utilizes fluorescent tubes with high-power-factor ballasts and an especially designed Plexiglas diffuser eliminates glare. Less

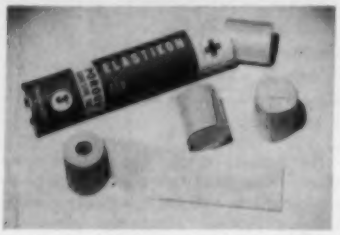
maintenance and smaller current consumption are economies claimed for the new Astrilite which has simplified wiring due to the incorporation of all lighting needs in the single unit. **American Sterilizer Co., Erie, Pa.**

For more details circle #459 on mailing card.

(Continued on page 208)

Elastikon Tape Is Porous Elastic

The skin can "breathe" under the new porous elastic adhesive tape introduced



by Johnson & Johnson under the "Elastikon" trade mark. Holes are created in the adhesive mass which permit perspiration to escape from the skin, increasing patient comfort and minimizing the possibility of adhesive tape irritation.

The new porous adhesive tape has high "stick" and stretch properties, is supplied in flesh tone, and comes in rack rolls cut in one, two, three and four-inch widths, each individually wrapped in protective glassine paper. **Johnson & Johnson, New Brunswick, N.J.**

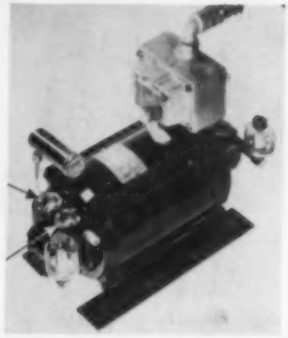
For more details circle #460 on mailing card.

Wax-Removing Compound Penetrates Layers of Wax

The new Holcomb "Wax Stripper" is a fast penetrant that gets through layers of old wax and will also take up the polyethylene base of many "no wax" floor finishes. A white powdered blend of several active ingredients, the scientifically-blended product mixes instantly with any water. "Wax Stripper" has a controlled sudsing action, is a fast emulsifier and a free rinser. It will not soften floors, bleed colors or cause fading and tests show it will not irritate the skin. It is shipped in 15 and 100-pound fiber drums. **J. I. Holcomb Mfg. Co., Inc., 1600 Barth Ave., Indianapolis 7, Ind.**

For more details circle #461 on mailing card.

Gomco Pump Design Simplifies Servicing

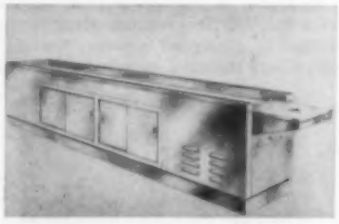


Servicing of filters in Gomco Explosion-Proof Hospital Model Suction and Suction-Ether Units is greatly simplified by a new pump design. The repositioned filters are now placed side-by-side on top of the pump head making both filters readily visible to the operator and easily accessible for servicing. The new easy-access filter design is incorporated in Gomco cabinet models serviced from the back, as indicated by arrows in the illustration, as well as in explosion-proof portable models. **Gomco Surgical Mfg. Corp., 828 E. Ferry St., Buffalo 11, N.Y.**

For more details circle #462 on mailing card.

Nylon Belting on Dish Handling Unit

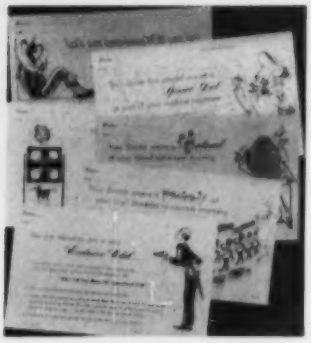
Dual Track Nylon Belting is a new feature of the Caddy-Veyor, a motor driven belt unit for easy and rapid handling of



dishes and trays. The Nylon Belt is self-tensioning, ensuring longer belt life. Belt links are self-tracking, eliminating the need for adjustment, and the endless belt has no splices. The nylon sections are rigid, shock resistant and cannot shred or ravel. The belt is easy to keep clean, does not absorb stains, and operates smoothly. The Caddy-Veyor is available in many combinations, facilitating installation to fit the needs of any food service development. **The Caddy Corporation of America, Secaucus, N.J.**

For more details circle #463 on mailing card.

(Continued on page 210)



Patient Card Series Gives Information Humorously

Cartoon-type sketches with humorous, easily understood descriptions explain hospital procedures to patients on Prep-Cards. Patients have more confidence and fewer fears when the cards are used as they give step-by-step details on six frequently used procedures. Cards now available cover surgery, blood chemistry test, G.I. series, special diet, gall bladder x-ray and B.M.R. Questions are answered and the information is readily available for repeated reference. **Franklin C. Hollister Co., 833 N. Orleans St., Chicago 10.**

For more details circle #464 on mailing card.

Hygienated Blankets Are Bacteria Resistant

Protection against the potential danger of infection from blankets is now applied to blankets manufactured at all Chatham mills. Blankets labeled Hygienated have received the antiseptic treatment which extensive hospital tests indicate makes them lastingly resistant to germs and bacteria.

A chemical called Permachem is the basic ingredient of the Hygienated process. The process was developed by Chatham after extensive research, study and experimentation in cooperation with the Permachem corporation. The bacteria-resistant chemical does not wash or wear off a Hygienated blanket, according to tests conducted, and has no visible effect on the texture, look or hand of the blanket, nor does the treatment affect the quality in any way. **Chatham Mfg. Co., 80 Worth St., New York 13.**

For more details circle #465 on mailing card.

V-Line Refrigerators for Bulk Food Handling

Loading, storage and serving of bulk foods are facilitated with the new V-line refrigerator models. Interiors can be changed without tools to handle varying types and sizes of pans and food racks for normal temperature refrigeration, combination normal temperature and freezer

and freezer or warming cabinets. They are available in one, two, three and four sections, in stainless steel, stainless steel and aluminum, baked white enamel, porcelain or other combinations of these finishes. **Victory Metal Mfg. Corp., Plymouth Meeting, Pa.**

For more details circle #466 on mailing card.

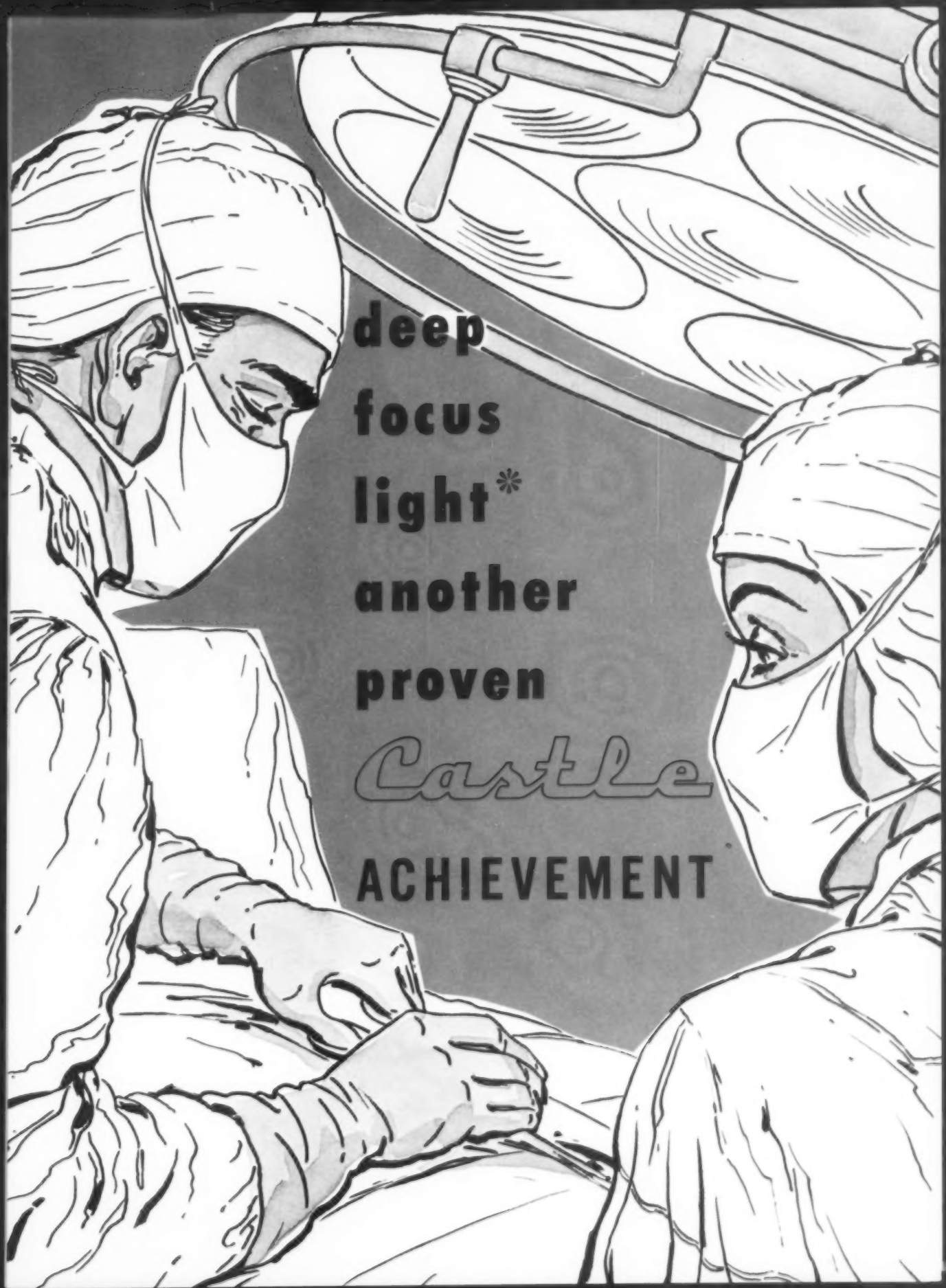
Four Acoustical Materials for Incombustible Ceilings

Golden and Silver Travertone, Deluxe Minatone and Gridtone are the four new deluxe acoustical materials recently introduced by Armstrong. Golden and Silver Travertone are both patterned after authentic travertine marble and contain hundreds of golden or silver flecks imbedded in the fissures. They offer high acoustical efficiency, light reflection and insulating properties.

Deluxe Minatone has a unique, non-directional arrangement of small perforations which extend onto the beveled edges of the tile, producing an unbroken pattern effect when installed. Newest of the metal pan type acoustical materials is Gridtone with a metallic facing of aluminum or steel and a mineral fiber pad bonded to the back. All of the new materials are incombustible. **Armstrong Cork Co., Lancaster, Pa.**

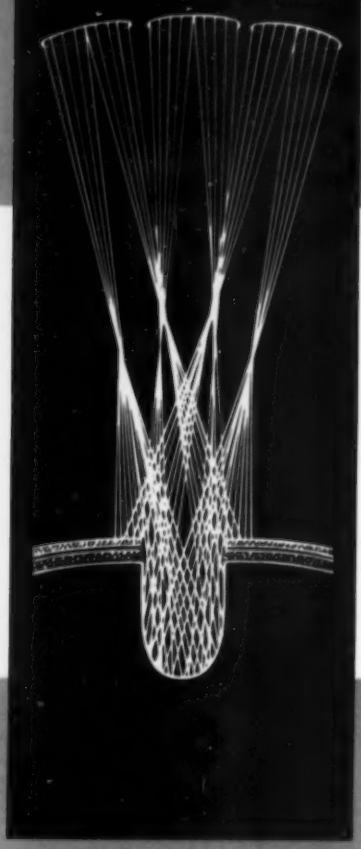
For more details circle #467 on mailing card.

(Continued on page 213)


deep
focus
light*
another
proven
Castle
ACHIEVEMENT

castle deep focus light

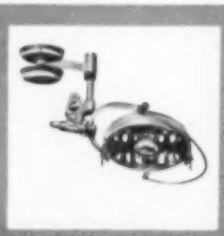
*light focused inside the surgical cavity



DEEP INSIDE the surgical cavity, the Castle light brings you a revealing flood of illumination. This is not simply light to work by, but illumination precisely controlled to work with you . . . to ease the danger of eye fatigue, to reduce shadows from the surgical team, to remain comfortably cool. And illumination that is pre-focused to eliminate fussy adjustments. Castle lights are always in focus DEEP INSIDE the surgical cavity. This is Deep Focus Light . . . a Proven Castle Achievement.

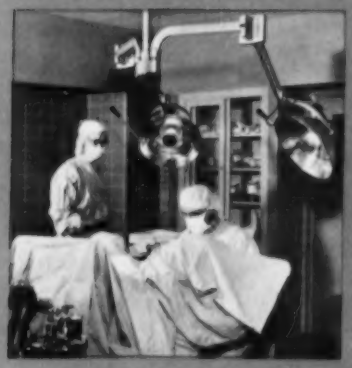
CROSS SECTION of Castle illuminating beam which provides a "trunk of light" in constant focus 30 to 60 inches from field. Drawing shows beams of light reflected from multi-step reflectors, going deep inside the surgical cavity.

THE CASTLE "18" LIGHT—an improved obstetrical light with new 23" reflectors.

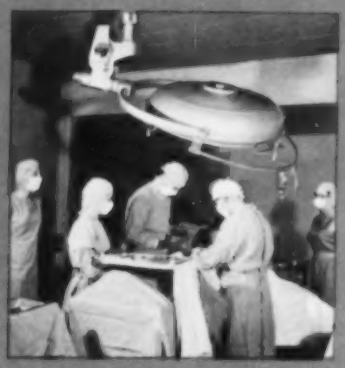


THE CASTLE "62" LIGHT—first to bring direct control of light to the surgical team.

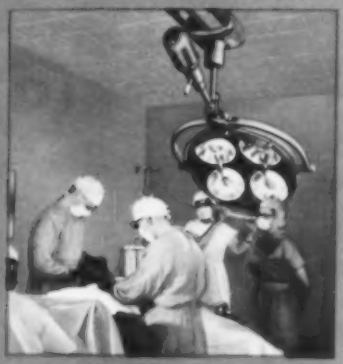
THE CASTLE "60" LIGHT—the new lower priced "60 Series" major surgical light.



"18" LIGHT'S Dual Illumination, light from two divergent sources, creates an effect similar to a major operating light. Twin pantograph arms allow the lampheads to be directed independently from varying angles—illuminating one or more areas in the surgical field.



THE "62" LIGHT—Difficult lighting is made easy by a "62" Light's **float action** mobility, permitting finger-tip control by the surgeon. Extreme side and end positions possible. Light beam illuminates walls as well as deepest portions of surgical cavity.



THE "60" LIGHT moves effortlessly along compact track, may be swung down to direct illumination from extreme low-angle side and end positions without crowding surgical team. The "60" may be fully extended or doubled back to "dead center" position.

Castle

Write for descriptive folder.

WILMOT CASTLE COMPANY

BOX 629, ROCHESTER 2, NEW YORK

PIONEERS IN SURGICAL EQUIPMENT SINCE 1883

Printed in U.S.A.

Vinyl-Clad Seat on Tubular Folding Chair

The all-steel tubular frame of the Durham No. 876 folding chair gives strength and rigidity. The extra large, curved 16 by 16-inch seat surface has deep sides and round corners for maximum comfort, and the russet-brown vinyl-clad finish gives the

appearance of leather. The finish is burn and marproof and does not change appearance with hard wear, even in outdoor use. **Durham Mfg. Corp., Muncie, Ind.**

For more details circle #468 on mailing card.

Puratize Protective Rinse Sterilizes Laundry

A germicidal-bactericidal compound known as Puratize Protective Rinse is a new sterilant said to render laundry lastingly bacteriostatic. It is a water-white, odorless liquid designed to be added to the final laundry rinse, either by hand or metered in. It is inexpensive and does not affect the hand, color or absorptive qualities of any fabric. Laboratory tests indicate that the new formulation kills a broad range of bacilli, including staphylococcus aureus, and renders the fabrics in effect self-sterilizing. **Puratize, Inc., Gallowhur Chemical Corp., Ossining, N.Y.**

For more details circle #469 on mailing card.

Linen Handling Cart of Lightweight Aluminum

Strong, light tubular aluminum forms the new Ferno Linen Cart. Quiet ball bearing wheels make it easy to handle and mesh aluminum sides keep linen from pushing off while providing ample ventilation. The five spacious shelves are braced on edges and center for maximum load carrying and the cart can be used for storage or distribution. It moves with minimum effort, easily maneuvered through narrow corridors and around turns. The tubular frame provides handles at each end to facilitate handling. The cart is available in two sizes. **Ferno Mfg. Co., Greenfield, Ohio.**

For more details circle #470 on mailing card.

Filter Grid Basket Supports Coffee Bag

Designed to assure freshness in coffee, a new filter grid basket introduced by Continental supports any standard coffee bag to prevent coffee grounds from soaking in the brew and thus distorting flavor. The filter grid basket fits any two, three, six or ten-gallon Continental urn and conforms to the specifications of the Coffee Brewing Institute. The grid bottom creates small pockets of filtration for better flavor extraction within the four to six-minute brewing period specified by the Institute.

Continental Coffee Co., 2550 Clybourn Ave., Chicago 14.

For more details circle #471 on mailing card.

(Continued on page 214)

Plastic Refuse Pail Is Sturdy and Quiet

A special durable plastic material forms the new 20-gallon refuse container introduced by Rubbermaid. It can be steam cleaned, and is unaffected by cold temperatures. A tight-fitting, snap-on lid protects contents and goes on quietly. The plastic does not absorb odors and is non-toxic, making the container suitable for food storage as well as refuse handling. The olive-green container is rustproof, dentproof and noiseless. **Rubbermaid Incorporated, Wooster, Ohio.**

For more details circle #472 on mailing card.

Kilit Ampule for Autoclave Control

A sealed unit carrying spore suspension in a green culture medium makes up the Kilit Ampule for autoclave control. It provides a positive check on steam sterilization technic by means of color and turbidity changes. When one or more ampules are placed in the autoclave load, they are incubated and checked for growth. If sterilization is accomplished, the Kilit Ampule remains green, whereas turbidity and a yellow color indicate inadequate autoclaving. The organism used meets the specifications of the National Institute of Health. **Becton, Dickinson & Co., Rutherford, N.J.**

For more details circle #473 on mailing card.

Folding Utility Truck Has Washable Cargo Bag

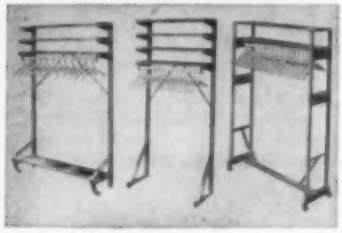
A washable canvas bag which hangs inside the frame by six brass grommets, fits into the new folding utility truck introduced by White. The lightweight unit is easily rolled in use, and the white 10-ounce duck bag can be closed by a drawstring for removal from the frame if desired. It has a capacity of five-bushels of waste. The truck folds to a compact four inches for storage and metallic parts are available in electro-galvanized or baked blue enamel finish. **White Mop Wringer Co., Fultonville, N.Y.**

For more details circle #474 on mailing card.

Borroughs Garment Racks Feature Three-Way Hanger Bar

A plated, mar-resistant, three-way hanging hanger bar which holds a basic number of hangers on the front side, or can be reversed from back to front to increase capacities, is a feature of the new line of Borroughs garment racks. The line includes wrap racks and wrap check racks in both floor and wall models. Hat shelves have three raised apex-ridges which are designed so that they do not collect dust.

The "Handee" rack is a compact, double-purpose rack which can be assembled in minutes without bolts or nuts, or quickly disassembled for storage. All racks have variable capacities and are finished in a choice of five baked-on enamel colors. **The Borroughs Mfg. Co., 3002 N. Burdick, Kalamazoo, Mich.**



For more details circle #475 on mailing card.

(Continued on page 216)

Disposable Needles in Pre-Sterilized Packet

The Sterile Hypostainless Disposable Needle is a low-cost needle with a nickel-plated brass hub and Hypostainless steel cannula. Each individual needle is contained in a pre-sterilized packet, pyrogen-free and ready for immediate use. Its factory sharp point assures smooth penetration and since it is used but once, then discarded, there is no problem of burred or dull needles. The time and effort required for cleaning and sterilizing needles are available for other work, and dangers of cross infection are eliminated with the Hypo Disposable Needle. The needles are packed in clear-front packages for easy handling and access, coded with the specific size of the contents. **Hypo Surgical Supply Corp., 11 Mercer St., New York 13.**

For more details circle #476 on mailing card.

Double Blood-Pack Unit for Convenient Separation

Designed to provide for the collection of whole blood and for its convenient, sterile separation into plasma, platelets and red cells for specific therapy, the new Double Blood-Pack(R) Unit is supplied sterile and pyrogen-free. The new unit permits the blood bank to provide whole blood or blood components conveniently and without waste of any part of the blood. The unit contains integral donor tube, hemorepellent plastic surfaces throughout and hemorepellent laminar flow phlebotomy needle. **Fenwal Labs., Somerville, N.J.**

For more details circle #477 on mailing card.

Asbestos-Cement Material Has Multiple Uses

Eleven years of research with Johns-Manville Colorlith, originally developed as a laboratory table top material, shows it to be a versatile product. Colorlith is a mixture of Portland cement and carefully selected asbestos fibers combined with chemically resistant colorings and fillings and subjected to hydraulic pressure to form a dense, homogeneous sheet whose surface can be polished to a high degree of smoothness while retaining a soft textured appearance. The product proves to be effective in walls, window sills and similar areas, baseboards, spandrels in curtain

wall construction, radiator enclosures, toilet compartments, shower stalls and shower rooms, sinks and fume hoods.

Colorlith is also effective as a decorative and durable wainscoting in lobbies, corridors, kitchens, locker rooms and rest rooms. It withstands abuse, is stronger than stone, and is supplied in sheets of workable size. In addition to its structural strength, Colorlith is highly resistant to most common acids and alkalies, is easy to maintain, and is now available in Cameo Brown and Surf Green in addition to the original Charcoal Gray. **Johns-Manville Corp., 22 E. 40th St., New York 16.**

For more details circle #478 on mailing card.

Plastic Serving Tray Has Wood Design

The wood grain design is molded into new Cambro plastic serving trays for permanency and attractive appearance. The trays are hand assembled with glass mats, steel frame and wood grain design to which liquid polyester resins are permanently bonded under heat and pressure. The result is an attractive tray with rugged wear resistance. **Cambro Mfg. Co., 214 Fifth St., Huntington Beach, Calif.**

For more details circle #479 on mailing card.

(Continued on page 218)

Lead Plastic Apron Clings for Protection

Assured protection is provided with the new lead plastic apron for x-ray laboratories recently introduced. The virtually indestructable apron clings close to the body when the technician leans over, affording maximum protection. The apron does not stain, is easy to clean and will stand up under most temperatures. **Picker X-Ray Corp., 25 S. Broadway, White Plains, N.Y.**

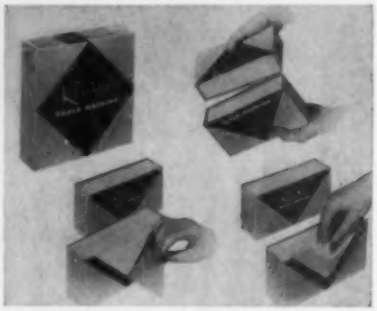
For more details circle #480 on mailing card.

Wall and Floor Sterilant for Surgical Suites

A rapid method of sterilizing hospital operating rooms and similar areas is produced by Celanese Corporation of America and introduced to the hospital field by Wilmot Castle Company. Intended for rapid sterilization of walls and floors in rooms or suites, the sterilant is a vaporous form of the chemical beta-propiolactone. When used on all exposed surfaces, the BPL sterilant permits re-entry for use of the room or suite within a few hours, shortening the usual time and the number of workers required for sterilizing such areas. **Wilmot Castle Co., 1931 E. Henrietta Rd., Rochester, N.Y.**

For more details circle #481 on mailing card.

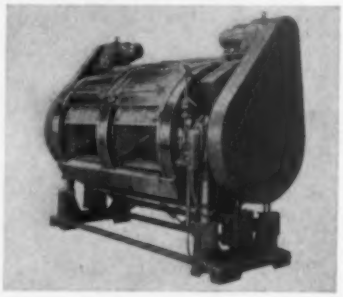
Kleenex Table Napkins in Dispenser Package



A distinctive box which converts into a handy dispenser now forms the package for Kleenex soft yet tough table napkins. It can be used as a dispenser on cafeteria counters or lunchroom tables, the design permitting the use of a half box at a time, or several opened dispenser halves can be arranged beside tray service areas or on bulk food conveyors. The new package is the same in appearance as the former box but the all-around center perforations permit quick opening to give access to 25 napkins in each half, folded ready for immediate service. **Kimberly-Clark Corp., Neenah, Wis.**

For more details circle #482 on mailing card.

Super Tilt-Out Washer Provides Maximum Efficiency



Designed to provide maximum efficiency in minimum space, the new Super Tilt-Out Washers measure up to 60 inches in diameter and up to 120 inches in lengths. Through use of pistons, the machine brings the cylinder and shell to a 30-degree tilt-out position, permitting the cylinder to move from the unload to the load position without inching the cylinder. Heavy gauge stainless steel forms both shell and cylinder and waterproof shell doors are not required. **Super Laundry Machinery Co., 1113 W. Cornelia Ave., Chicago 13.**

For more details circle #483 on mailing card.

(Continued on page 220)

See how this **new Edison VOICEWRITER** dictating machine helps you break through your "time barrier" to new success!

You'll take the mike . . . dictate . . . and suddenly you'll realize that any other dictating method is now old-fashioned!

You'll see how this all-new Voicewriter saves man-hours by acting as a rapid, foolproof dispatcher of correspondence . . . a communicator of instructions . . . a conference reporter . . . a sounding board for sales talks, ideas and speeches! Its features? All you would expect to find in the finest dictating machine ever built . . . and then some!

Think we've exaggerated? We offer you a friendly challenge to mail the coupon—"take the mike" at your own desk, with your own work, for just a few minutes! Once you take the mike...*your* talk will be our best sales talk!

Edison Voicewriter

A product of Thomas A. Edison Industries, McGraw-Edison Company, West Orange, N.J. In Canada: 32 Front Street W., Toronto, Ont.

McGRAW EDISON

FREE TRYOUT!—Just fill out and mail this coupon to Edison Voicewriter, West Orange, New Jersey. Your Voicewriter representative will do the rest. No obligation!

• • •

Okay Edison, I'd like to take the mike of the all-new Edison Voicewriter. Please call me to arrange a demonstration.

Name_____

Title_____

Organization_____

Address_____

City_____ Zone____ State_____

Fire Retardant Paint Slows Fire-Spread Rate

While the new DuPont interior flat enamel does not stop fire, it slows down the spreading rate as the material is fire retardant. The paint, which foams and forms a spongy insulating layer when subjected to heat, is the result of five years of research. It is equal in appearance to the finest finishes and is available in seven colors and white. It can be applied by brush, roller or spray gun and the manufacturer recommends three coats for optimum results, especially in stair wells, maintenance departments, kitchens and other areas where fires might be more apt to start. Underwriters Laboratories tests on the new paint give it good ratings in the flame spread, fuel contributed and smoke developed classifications. **E. I. du Pont de Nemours & Co., Wilmington, Del.**

For more details circle #484 on mailing card.

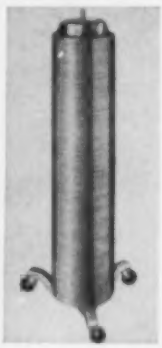
Bactericidal Detergent for Cold Glass Washing

Iodet is the name given to a new bactericidal detergent for cold glass washing. It gives a quick, sure washing action on glasses and eating utensils, with rinse run-off and potent germ killing effect without the need for heat. Iodet is non-toxic and non-allergenic, is instantly soluble in water and is low in foam. It is supplied in ½-gallon containers. **The DuBois Co., Inc., 1120 W. Front St., Cincinnati 3, Ohio.**

For more details circle #485 on mailing card.

Rolls-Rack Holds Food Service Covers

Zoia food covers or rings to help keep food warm and sanitary until placed before the patient are now easily handled in food service areas with the new Rolls-Rack. More than 100 covers or rings can be stacked on one Rolls-Rack, ready for instant use in covering plates of food. Space and labor saving is effected in transportation and storage, and handling is reduced, thus reducing opportunities for contamination. The Rolls-Rack has a sturdy cast aluminum base with silver finish and rolls easily on three 2½-inch ball bearing hard rubber casters. The low center of gravity and three-point suspension facilitate movement without danger of tipping. **Zoia Banquetier Co., Inc., 4125 Payne Ave., Cleveland 3, Ohio.**



For more details circle #486 on mailing card.

Toro Whirlwind Mowers Give Three-Season Use

Three years of research and experimentation went into the design of the new Toro Whirlwind Mowers. A full-circle expanding wind-tunnel under the housing creates a super-powerful vacuum that "freezes" every blade of grass upright for a crisp, clean cut. The new cutting principle gives the mowers three-season use since they can effectively clean up the yard in spring, bag clippings in the summer and bag or mulch leaves in the fall.

They are available in a variety of sizes and styles to meet every need of lawn care and are constructed for long, trouble-free service. The low silhouette operates under low-hanging shrubbery and the lowered center of gravity gives greater safety on side hills. The housing is carefully engineered for maximum safety. **Toro Mfg. Corp., 3042 Snelling Ave., Minneapolis 6, Minn.**

For more details circle #487 on mailing card.

(Continued on page 222)

more than tetracycline alone

MYSTECLIN-V CONTAINS TETRACYCLINE PHOSPHATE COMPLEX FOR A DIRECT ATTACK ON THE PRIMARY INFECTION

Mysteclin-V strikes directly at all tetracycline sensitive organisms—most pathogenic bacteria, certain large viruses, Endamoeba histolytica. It provides all benefits of tetracycline in the effective phosphate complex form.[1] Patient response is rapid because initial high peak blood serum levels may be maintained easily at the antibacterial attack level until the infection is conquered.

MYSTECLIN-V CONTAINS MYCOSTATIN FOR A SPECIFIC DEFENSE AGAINST SECONDARY MONILIAL SUPERINFECTION

Mysteclin-V protects patients against antibiotic induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis. This protection is provided by Mycostatin, the antifungal antibiotic, with specific action against Candida (Monilia) albicans.[2]

BOTH ARE OFTEN NEEDED WHEN BACTERIAL INFECTION OCCURS

MYSTECLIN-V

SQUIBB TETRACYCLINE PHOSPHATE COMPLEX (SUMYCIN) AND NYSTATIN (MYCOSTATIN)

Capsules (250 mg./250,000 u), bottles of 16 and 100.
Half-strength Capsules (125 mg./125,000 u), bottles of 16 and 100.
Suspension (125 mg./125,000 u per 5 cc.), 2 oz. bottles.
Pediatric Drops (100 mg./100,000 u per cc.), 10 cc. dropper bottles.

References: 1. Cronk, G. A.; Naumann, D. E., and Casson, K.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia Inc. 1958, p. 397. 2. Newcomer, V. D.; Wright, E. T., and Sternberg, T. H.: Antibiotics Annual 1954-1955, New York, Medical Encyclopedia Inc., 1955, p. 686.

SQUIBB Squibb Quality—the Priceless Ingredient

For additional information, use postcard facing Cover 3.

Food Service Conveyor for 65 Patients

Hot food service for 65 patients can be handled in the new Colson bulk food service conveyor. It is designed to keep food hot from the central kitchen to the tray set-up area. The stainless steel Model BFS 431 conveyor is 29½ inches wide and 56 inches long with a convenient top deck work area 38 inches high. Four 8½-quart round food wells, three 4-quart round food wells and a 16-quart meat pan are set in the top deck with inset wells integrated to form a crevice-free surface for ease in cleaning. Each round well has a six-inch metal-encased plate heating element and two plate heaters assure a continuous even flow of heat to the meat pan.

Other features of the new bulk conveyor include a meat tray cover which functions as a serving shelf when open; safety recessed electrical control panel with automatic temperature selector; stainless steel utility drawer; double storage compartments in the lower section with disappearing overhead doors, each with shelves, and two rigid and two swivel eight-inch casters for easy maneuverability. **The Colson Corp., 7 S. Dearborn St., Chicago 3.**

For more details circle #488 on mailing card.

Heavy Duty Floor Machines Have Two-Speed Motors

Two-speed ½ and ¾ h.p. motors are built into the General KC Heavy Duty Floor Maintenance Machines. These include the KC-214 with 15-inch brush

spread, the KC-216 with 17-inch brush spread, the KC-218 with 19-inch brush spread and the KC-220 with 21-inch brush spread. With the two-speed motors, speed can be reduced to 105 RPM for scrubbing, waxing, wire scrubbing or rug shampooing. For polishing, buffing or dry cleaning the speed is switched back quickly to the 160 RPM speed without stopping the motor. **General Floorcraft, Inc., 3630 Rombouts Ave., Bronx 66, N.Y.**

For more details circle #489 on mailing card.

Electrostatic Printer Makes Low-Cost Enlargements

Enlargements of microfilmed drawings and records can be made at economical cost with the new Bruning Copytron Model 1000 Enlarger-Printer. A new electrostatic principle is employed in the operation of the machine to produce permanent, black-on-white enlargements of records and

drawings which have been reduced to 35mm microfilm size. It enlarges microfilm 14 to 16 times and prints the enlargements on sheets ranging from 1½ by 11 inches to 18 by 24 inches. Finished prints are delivered at the rate of about four per minute. The machine is self-contained and consists of two sections, the enlarger and the reproducer. **Charles Bruning Co., Inc., 1800 W. Central Rd., Mount Prospect, Ill.**

For more details circle #490 on mailing card.

(Continued on page 224)

ONLY CARRIER OFFERS ICEMAKERS WITH CERTIFIED CAPACITY

There are 16 Carrier ice machines to give you exactly the kind of ice you need, cubes, crushed, flakes or chips. You can be sure you'll get the amount of ice you expect, too, because every Carrier ice machine comes with capacity certified in writing.

There are no "up to" qualifications. There are no "average" production figures. Capacity is determined according to air and water temperatures where you are.

You can save as much as 80% on ice with a Carrier Icemaker. Your Carrier dealer will give you the exact figures—and a lot of other trustworthy facts. Call him. He's listed in the Yellow Pages under Ice Making Equipment. Or, write to Carrier Corporation, Syracuse 1, New York.

Carrier AIR CONDITIONING • REFRIGERATION

Liquid Oxygen Cylinder Saves Storage Space

Maximum oxygen supply in minimum area is provided in the new AR-3 Liquid Oxygen Cylinder introduced by Ohio Chemical. Each cylinder, 58 inches high and 20 inches in diameter, has a capacity of 3000 cubic feet of oxygen. It can be easily handled by one man as weight and area are but a small fraction of that for gaseous oxygen of the same amount.

The new Ohio liquid oxygen manifold consists of two banks of one or more AR-3 cylinders, both banks connected to a control cabinet, one serving as an "in service" unit and the other as a reserve supply. Constant dynamic line pressure during switch-over is assured by a regulator. **Ohio Chemical & Surgical Equipment Co., 1400 E. Washington Ave., Madison 10, Wis.**

For more details circle #491 on mailing card.

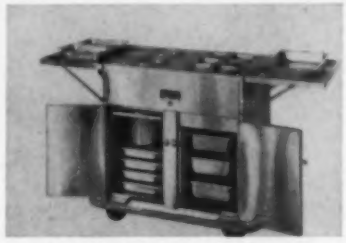
Heinz Ketchup in Portion Pack

Sanitation, cleanliness and convenience are combined with savings in costs in the new single-service containers of Heinz Ketchup. One-half ounce of Heinz Ketchup is sealed inside an aluminum-foil envelope one and three-quarters by four inches in size. It provides clean, convenient service on patient trays and in cafeterias and lunchrooms, without waste. Ketchup quality is maintained for months inside the package. **H. J. Heinz Co., Pittsburgh 30, Pa.**

For more details circle #492 on mailing card.

Hot and Cold Food Cart Has "Cold-Conditioned" Area

An optional dry or moist heat top section, lower heated compartment and a "cold-conditioned" food compartment are features of the new Atlas Model 572 Portable Electric Hot and Cold Food Cart. The mobile, self-contained unit, with the top covers opening out to function as full serving shelves, may be plugged into any standard electric outlet. Each compartment is controlled by a separate electric thermostat, with individual pilot lights, mounted on a



recessed-type control panel. The top compartment is convertible to either dry heat or moist heat and is provided with a drain for quick, easy clean-out.

The new cart serves complete meals for 220 children or 150 adults. The interchangeable topdeck equipment will handle varying requirements of diversified menus and special diets. The Model 572 functions as a food transportation unit and as a food serving facility in the serving area. **Atlas Div., National Cornice Works, 1323 Channing St., Los Angeles 21, Calif.**

For more details circle #493 on mailing card.

Wash Room Cart #1115 Carries Equipment and Supplies

Developed as a result of time and motion studies, and other research conducted in cooperation with building and maintenance managers and personnel, the Wash

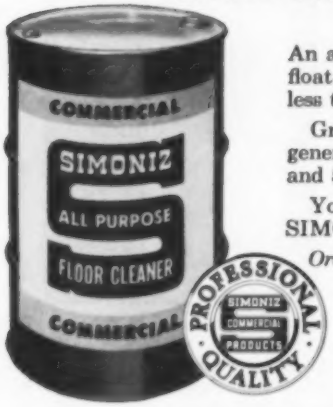
Room Cart #1115 combines all equipment in one unit. Everything required for sanitary wash room maintenance is carried within easy reach on the cart. Clips hold broom, mop and plunger while areas are provided for all supplies, standard mop pails and mop press and a large draw string waste bag. The practical cart moves easily on four-inch rubber self-lubricating casters, two stationary and two swivel. The sturdily constructed body of tubular and light body steel has aluminized finish. **Forbes Brothers Co., 810 Santa Fe Ave., Los Angeles 21, Calif.**

For more details circle #494 on mailing card.

(Continued on page 226)

GET 3-WAY ACTION

WITH SIMONIZ ALL-PURPOSE CLEANER!



An all-purpose cleaner can be a fact, and this one will prove it to you. Deep-reach, float-off action is the secret—brightens as it cleans. Neutral-mild concentrate is harmless to skin and clothing, harmless to any type of floor or washable surface.

Graded solutions make it ideal for marble, terrazzo, or waxed floor maintenance—general cleaning—and safe speedy wax or finish-stripping. It's available in 1-, 5-, 30- and 55-gallon sizes.

You're always sure of professional quality that's sensibly priced, too, because—SIMONIZ MAKES IT.

Order from your Simoniz Commercial Products Distributor, or mail the coupon today!

SIMONIZ®

FOR LONG WEAR-LESS CARE

Heavy-Duty Floor Wax • Non-Scuff Floor Finish • Super Anti-Slip Floor Finish • Triple "A" Paste Wax • Heavy-Duty Vinyl Sponge • All-Purpose Concentrate Floor Cleaner • HiLite Furniture Polish

Simoniz Company (Commercial Products Division—MH-5)
2100 Indiana Avenue, Chicago 16, Illinois

☐ Without obligation, please send details on new Simoniz All-Purpose Concentrate Floor Cleaner.

☐ Please send name of nearest Simoniz Distributor.

Name_____ Title_____

Firm Name_____

Street Address_____

City_____ State_____

For additional information, use postcard facing Cover 3.

High-Speed Centifuge for Micro-Chemistry Determinations

Especially designed for micro-chemistry determinations, the new Adams high-speed centrifuge utilizes the angle principle for quick, efficient centrifugation and accommodates both glass and disposable plastic tubes. The versatile machine handles tubes of three different sizes, made possible by two sets of specially designed polyethylene adapters. The machine runs quietly, owing to precision machining, perfect balance of the head, and shock-mounting of housing, motor and head. Separate ventilating systems for head and motor chambers prevent overheating. A special angle head cover assures complete safety in operation. **Clay-Adams, Inc., 141 E. 25th St., New York 10.**

For more details circle #495 on mailing card.

21 Models Added to Emergency Power Plant Line

Both gasoline and Diesel driven models are among the 21 added to the Onan line of emergency electric power plants. The new models will produce from one to 200 kilowatts of power each, depending upon the model, providing a wide choice of standby power for every need. The largest new gasoline units in the line now provide 150 kilowatts while the largest Diesel unit will produce 200 kilowatts, making greatly increased power available.

Eight new high capacity plants are available in the line of Onan Diesel electric plants. They are designed to meet the needs for auxiliary Diesel emergency electric power in hospitals and other institutions where dependable standby power is vital to continuous operation. The new Diesel driven plants have the necessary power to operate essential electrical loads such as automatic heating systems, air conditioners, elevators, communications systems, motors and lights for as long as services are required. **D. W. Onan & Sons Inc., 2515 University S.E., Minneapolis 14, Minn.**

For more details circle #496 on mailing card.

Mobile Dish Dollies in Four Sizes

The Bucksco Poker Chip Dish Dollies are mobile dish handling units fabricated entirely from aircraft aluminum. They are lightweight, sanitary and easily maneuverable and designed in the proper height to fit under work tables and counters. Dishes can be placed directly in the dollies from dishwashing machines, saving time and reducing breakage. The units are now available in four sizes to accommodate dishes from four to ten inches in diameter. All models are available with heating units for warming dishes, and with plastic dust covers, as shown in the illustration. **Bucks County Enterprises Inc., Quakertown, Pa.**

For more details circle #497 on mailing card.

Electronic Pocket Page Signals When Dialed

When the switchboard operator dials the number of a doctor or other individual on

the Personal Page dial, a signal tone alerts him to the call and he picks up the nearest telephone for the message. The miniature transistorized receiver is completely self-contained, is small enough to wear in a pocket or attached to a belt, and gives private, selective paging. The signal tone continues until the user depresses the silencer button, making the unit ready for the next call. The receiver is unaffected by shock or vibration. **Hanak Engineering Co., 7 Heather Rd., Bala-Cynwyd, Pa.**

For more details circle #498 on mailing card.

(Continued on page 228)

for better all-around bedside waste disposal

Neat, clean, convenient, completely disposable

•

Eliminates use of adhesive tapes

•

No more safety pins to damage sheets

•

No need for costly, cumbersome wire frames and unsightly brown paper bags

believe me, there is only ONE

STIK-BAG PAT. PEND.

and it's by IPCO

TAB IT ON wherever you want it: to bed, cabinet, wall . . . in the nursery, etc. Sticks to everything and peels off easily with no marring to surface. AND, SO ECONOMICAL . . . it will pay for itself in savings on linens alone—so widely abused by use of damaging safety pins.

Write for Free Stik-Bag Samples

a complete source for hospital supplies and equipment

IPCO HOSPITAL SUPPLY CORP.

161 SIXTH AVENUE • NEW YORK 13, N. Y.

OTHER OFFICES: CHICAGO 45, ILL., DALLAS 35, TEXAS

Economy and Efficiency in Portable Photocopy Machine

The new Apeco Director "Auto-Stat" is a compact photocopy machine which is

lightweight and portable. It is economical in price, yet combines a unique "speed feed" feature with excellent performance. It is a desk-top model which will reproduce any original document of office size in a matter of seconds. Features of the new model include single pushbutton control, continuous automatic feed operation and functional styling which facilitates maintenance. **American Photocopy Equipment Co., 2100 Dempster, Evanston, Ill.**

For more details circle #499 on mailing card.

Floors and Carpets Cleaned With Gyro-Magic Machine

The Gyro-Magic floor machine is designed for heavy duty use, yet it is light enough to be handled by maids. It is a triple-use machine since it will shampoo carpets, scrub floors or wax and polish a floor. Carpet cleaning and floor scrubbing can be done with the same "even-flo" brush and a softer brush or steel wool or lambswool pad is used for polishing. A three-way handle adjusts for self-propelling action and the 12-inch brush is fed from a gallon-and-a-half solution tank. **Advance Floor Machine Co., 4100 Washington Ave. N., Minneapolis 12, Minn.**

For more details circle #500 on mailing card.

"Space-Maker" Bedside Cabinet Serves One or Two Patients

Convenience, stability, economy and flexibility are combined with space saving in the new "Space-Maker" Bedside Cabinet. Supplying the needed storage space for one or two patients, the cabinet has a single unit anodized aluminum frame designed to take years of hard use, with laminated plastic top and sides for minimum maintenance. Either Formica or Nevamar may be specified in colors and grains to match the room decor.

The "Space-Maker" is 19½ inches deep and 31½ inches wide, providing top area sufficient for one or two patients. When used lengthwise along the bed, the patient has three adjustable shelves and a drawer for private storage and the compartment

on the back can be used for storage of utensils, blankets, supplies and the like. When used for two patients, each has three adjustable shelves in the storage area and a drawer. Drawer locks have separate master keys for each nursing unit. Swivel casters with rubber covers make the cabinet easy to move. Towel bars are available as accessories if desired. **Hospital Supply & Development Co., 3109 Forbes Ave., Pittsburgh 13, Pa.**

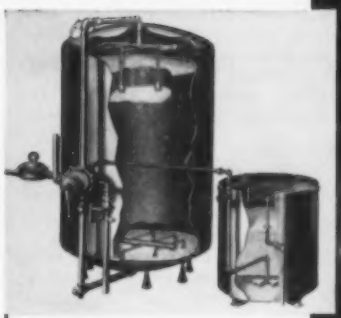
For more details circle #501 on mailing card.

Improved Anchor Hinge Has Increased Holding Strength

Greater holding strength for metal or wood doors, where door holders or closers are used, is provided in the new, improved Anchor Hinge. Design features include a longer, narrower anchor plate which fits into the top of the door to tie the door style and top rail together. Two of the six screw holes are positioned into the top rail of the door for increased strength despite severe stress and strain. Both door and joint leaves have narrowed anchor plate to permit complete concealment for a neater appearance. The new hinge is available in two models: Model T 4A 3392 for use with surface-applied door holders or closers; and Model T 4A 3393 for use when door holders or closers are concealed in the top of the door. **McKinney Mfg. Co., 1713 Liverpool St., Pittsburgh 33, Pa.**

For more details circle #502 on mailing card.

(Continued on page 230)



Only "Double-Check" gives you 44% more softened water

Some people think they can have "double-check" performance without using the "double-check" softener, but Elgin "Double-Check" users know better! This exclusive Elgin principle assures them up to 44% more soft water per regeneration from a softener of given size . . . prevents loss of zeolite . . . saves salt. Three types of control: manual multiport as illustrated above, automatic multiport, and "ultramatic" as in large illustration.

Dealkalizers

prevent corrosion of steam condensate return lines and equipment.

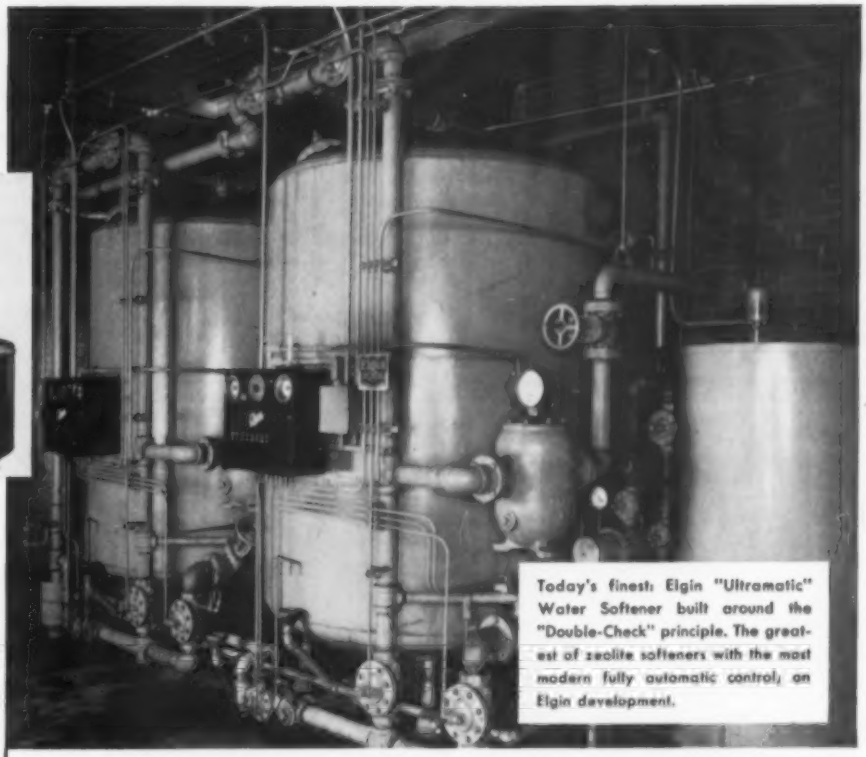
Deionizers

produce mineral free water equivalent to distilled water for most hospital uses—but produced at a fraction of distillation cost.

Deaerating Heaters

supply dollar-saving pre-heated boiler water, free of corrosive CO_2.

- Elgin services also include modernizing existing softeners, often with almost incredible gains in soft water output. Our representative will survey possibilities without cost or obligation.



Today's finest: Elgin "Ultramatic" Water Softener built around the "Double-Check" principle. The greatest of zeolite softeners with the most modern fully automatic control, an Elgin development.

Modernizing?

Don't overlook water conditioning!

There are two kinds of hospital modernization: the glamour kind and the basic kind. Glamour has its place, but never let it override the basic equipment that writes the real story of operating efficiency and profits.

There is no better example of basic equipment essential to every modernization or expansion program than the Elgin equipment illustrated and described here: The Elgin "Double Check" Water Softener with its unduplicated advantages. Elgin Dealkalizers to protect condensate piping. Elgin Deionizers to supply chemically pure water at a fraction of the cost of distillation. Elgin Deaerating Heaters to cut fuel costs and prevent corrosion.

Yes, while you're modernizing, modernize all the way through with Elgin equipment. Read the facts about Elgin equipment and services opposite. Ask for bulletin covering Elgin's longer and broader experience, or better still let us put you in touch with your local Elgin representative.

ELGIN
WATER CONDITIONING
SINCE 1908

ELGIN SOFTENER CORPORATION
144 No. Grove Ave., Elgin, Illinois
Representatives in principal cities
In Canada: G. F. Sterne & Sons Ltd., Brantford

Pharmaceuticals

Cor-Tyzine and Neocor-Tyzine

Coordinated treatment of inflammatory nasal conditions can be effected with two new products recently introduced, Cor-Tyzine and Neocor-Tyzine. They unite the decongestive action of Tyzine with the anti-inflammatory action of prednisolone for the relief of rhinitis, sinusitis and other allergic nasal conditions. Neocor-Tyzine also contains the broad-spectrum antibiotic neomycin for the treatment of associated bacterial infection. Both products are available in 15 cc. bottles and in half-strength Pediatric Nasal Drops. **Chas. Pfizer & Co., Inc., 800 Second Ave., New York 17.**

For more details circle #503 on mailing card.

Deluteval

Deluteval combines the progestational steroid ester Delalutin with the estrogenic steroid ester Delestrogen to provide a long-acting sterile hormone preparation formulated to help restore normal ovarian function. It is supplied in 2 cc. ampuls for intramuscular injection and is convenient to administer, assuring optimal hormonal relation in sustained-action therapy. It is indicated in dysfunctional uterine bleeding, amenorrhea and other disturbances of the menstrual cycle for non-pregnant women, and in habitual or recurrent abortion and in threatened abortion for pregnant women. **E. R. Squibb & Sons, Div. of Olin Mathieson Chemical Corp., 745 Fifth Ave., New York 22.**

For more details circle #504 on mailing card.

Stenisone

Stenisone is developed to provide safely useful prednisone therapy. Stenisone contains prednisone, the potent, anti-inflammatory steroid, and methandriol, a relatively non-virilizing anabolic steroid, and antacid ingredients which help to combat the tendency to produce peptic ulcer. Stenisone is described as more safely useful wherever adrenal steroids of the hydrocortisone type are indicated. It is packaged in bottles of 30 and 100 scored oral tablets. **Organon Inc., Orange, N.J.**

For more details circle #505 on mailing card.

Simron

Simron is a new low-dose iron for the treatment of iron deficiency anemia. A special absorption agent eliminates the need for massive doses of iron to attain therapeutic quantities in the blood. Each soft-gelatin capsule contains 10 mg. elemental iron as ferrous gluconate and a special absorption agent. They are supplied in bottles of 100. **The Wm. S. Merrell Co., Cincinnati 15, Ohio.**

For more details circle #506 on mailing card.

Celginace and Combinace

Celginace and Combinace are two new anticonstipants combining a new bulking agent with dioctyl sodium sulfosuccinate. They are available in tablets and granules. Celginace combines Colace, which promotes proper hydration of fecal material, and the new hydrasorbent, calcium and codium alginates, for bulk. Combinace contains Peri-Colace, a combination of Colace and Peristim, in addition to the alginates. **Mead Johnson & Co., Evansville 21, Ind.**

For more details circle #507 on mailing card.

Deronil

Deronil is a new steroid hormone active in the treatment of various rheumatic, allergic, dermatologic and ocular diseases. It offers improved anti-inflammatory effect with much lower dosages and is supplied in an 0.75 mg. tablet in bottles of 50 and 500. **Schering Corp., 96 Orange St., Bloomfield, N.J.**

For more details circle #508 on mailing card.

Literature and Services

• **Edition 43** of the **"Ellison Balanced Door"** catalog is now available from the Ellison Bronze Co., Inc., Jamestown, N.Y. The catalog gives specifications and factual data and is profusely illustrated with photographs of installations.

For more details circle #509 on mailing card.

• Complete technical data on **Erie Porcelain Enamel curtain wall and veneer panels** are presented in a bulletin released by Erie Enameling Co., Erie, Pa.

For more details circle #510 on mailing card.

• The benefits to hospitals of unitizing microfilmed records are discussed in a four-page folder available from the Ozalid Division of General Aniline and Film Corp., 29 Corliss Lane, Johnson City, N.Y. The dry-process duplicator known as the Unitizer, the Actifilm Printer and Actifilm sheet film in card weights and sizes are described and illustrated in the brochure entitled **"There's a New Way to Keep Your Medical Records Straight."**

For more details circle #511 on mailing card.

(Continued on page 232)

DuKane

fully automatic

hospital communications system

Automatic . . . flexible . . . expandable . . . The DuKane Hospital Communications System is the modern successor to nurses' call systems. From this attractive, functional master unit, the duty nurse can answer patients' calls, automatically, by simply pressing  a button. Or, she can answer selectively by dialing just two digits.  Or, she can dial rooms, duty stations, or corridor reply stations and talk with all locations.

With DuKane, she has a complete floor communications system. Modern, attractive bedside stations  incorporate combinations of features needed for modern hospital usage. Lavatory stations and emergency stations, too.  Corridor door lights  corridor answering stations  and even wireless voice paging to individual doctors  are engineered into DuKane systems as needed.

You get special features and tailor-made flexibility because DuKane systems are custom engineered from mass-produced components. Your nearest DuKane man is listed in the Yellow Pages  He is a factory-trained engineering distributor who will act as your consultant on any sound system or communications problem.

DuKane
CORPORATION
ST. CHARLES, ILLINOIS

DuKane Corporation, Dept. MH-59, St. Charles, Illinois
Please send me more information about the new DuKane Hospital Communications System.

Name_____

Firm or Hospital_____

Address_____

City & State_____

• **Labor-saving equipment and new products** designed to save time, effort and money in food service installations are featured in the comprehensive new catalog recently released by Bloomfield Industries, 4546 W. 47th St., Chicago 32. The many items in the line of food and maintenance service equipment are described.

For more details circle #512 on mailing card.

• How to obtain low cost painting best suited for lasting results for both interior and exterior applications is discussed in a 16-page brochure entitled, **"Your Next Paint Job."** Prepared by The Tremco Mfg. Co., 8701 Kinsman Rd., Cleveland 4, Ohio, the comprehensive brochure provides a quick reference guide for producing a satisfactory finishing job at the lowest cost.

For more details circle #513 on mailing card.

• **"The Tornado Method of Furnace and Boiler Cleaning"** is discussed in a four-page brochure published by the Breuer Electric Mfg. Co., 5100 N. Ravenswood Ave., Chicago 40. The result of a lengthy study of boiler cleaning problems and heat transfer loss occurring in soot-covered boiler tubes, the leaflet explains how savings can be realized in fuel bills.

For more details circle #514 on mailing card.

• **Ranfac Surgical Catalog S-95,** available from the Randall Faichney Corp., 299 Marginal St., Boston 28, Mass., gives descriptive information on Ranfac syringes and needles, transfusion and infusion units, thermometers, plastic tubing and other surgical supplies. Disposable units are also described and illustrated.

For more details circle #515 on mailing card.

• **Quick,** detailed information on new products for the modern washroom is supplied in the **1959 Crown Washroom Cabinet Catalog** issued by Crown Zellerbach Corp., P.O. Box 3475, San Francisco, Calif. Descriptive information is supplied on Crown tissue and towel dispensers and architectural specifications and instructions for use of cabinet supports and adhesives are also included.

For more details circle #516 on mailing card.

• **"Intramuscular Iron Therapy"** is the title of a film released by Lakeside Laboratories, Inc., Medical Education Dept., Milwaukee 1, Wis. The picture, in color and sound, was filmed in England and the United States with leading hematologists of both countries reporting on new indications for intramuscular administration.

For more details circle #517 on mailing card.

• Full information on low cost, permanent drinking tubes which can be sterilized are given in a leaflet entitled **"The Last Drinking Tubes You'll Ever Have to Buy!"** Published by the Anchor Plastics Co., 36-36 Thirty-Sixth St., Long Island City 6, N.Y., the folder discusses advantages of use of the rigid, heavy gauge tubes in institutions with permanent and semi-permanent patients.

For more details circle #518 on mailing card.

• **"Controlling Indoor Weather"** in new or modernized buildings is discussed in a 20-page brochure published by Johnson Service Co., 507 E. Michigan St., Milwaukee 1, Wis. Presenting a 16-city report on what buildings are doing about automatic temperature control, the booklet discusses modern controls for ideal temperatures, and reduced heating and cooling costs.

For more details circle #519 on mailing card.

• The current edition of the informative booklet, **"The Processing of Nursing Bottles,"** is now available from The Southern Cross Mfg. Corp., Chambersburg, Pa. The 1959 edition contains 22 pages of factual information presented in editorial style with time study of the flow system, arrangement of the nursery wash room and formula preparation room and data on the Formula Room Consultant Service. All information is illustrated by photographs and charts.

For more details circle #520 on mailing card.

• An **Application Manual, Bulletin No. 454,** pertaining to all types of resistance measurements in hospitals, is now available from the Herman H. Sticht Co., Inc., 27 Park Place, New York 7. Exact requirements of N.F.P.A. Bulletin No. 56 on "Recommended Safe Practice for Hospital Operating Rooms" are given, with information on how the tests are performed with the Model F-2 Conductivity Test Kit.

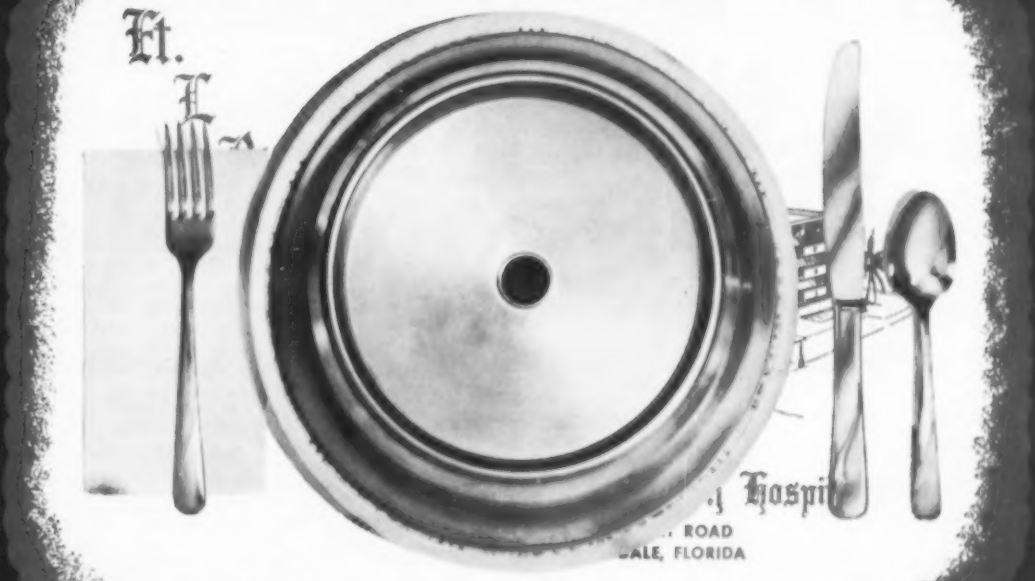
For more details circle #521 on mailing card.

• The complete line of electric water coolers manufactured by Cordley Hayes, 443 Fourth Ave., New York 16, is illustrated and described in **Catalog No. 59.** The 20-page book covers all Cordley models, giving capacity data, technical and roughing-in details, and showing photographs of interior construction. Hot-Tap attachments, Cordley-Rac for wall suspension and other accessories are also included.

For more details circle #522 on mailing card.

(Continued on page 234)

PATIENT PICK-UP



This simple addition to tray meals acts like a tonic . . . perks up patients' appetites. Roylies and Roylprints (tray mats, doylies and printed paper place mats) lend a welcome touch of color . . . lift spirits, reduce noise of dish clatter. Crisp, sanitary, immediately disposable, and cost so little. In stock designs and colors or special printing. Would you like a day's supply, free? Write Royal, Dept. H , for details.

Roylies
PAPER TRAY MATS AND DOYLIES

Roylprints
PRINTED PAPER PLACE MATS

ROYAL LACE PAPER DIVISION STAR-PAK BROOKLYN 1, NEW YORK
Standard Packaging Corporation

• A 24-page booklet, **"Radiation Monitoring with Kodak Personal Monitoring Films,"** is available from Special Sensitized Products Sales Div., Eastman Kodak Co., Rochester 4, N.Y. The photographic method of obtaining accurate and permanent records of radiation dosage is outlined and information is given on the four types of Kodak film used for the purpose.

For more details circle #523 on mailing card.

• **"New Cost-Cutting Recipes"** created by Campbell chefs are given in a colorfully illustrated booklet available from Campbell Soup Co., Institutional Div., Camden 1, N.J. The institutional recipes provide simplified methods of preparation of eight main dishes for tempting patients' appetites.

For more details circle #524 on mailing card.

• Typical mortuary rack and refrigerator arrangements scientifically designed and manufactured by the Market Forge Co., Everett 49, Mass. are described in a new four-page **folder, R-343.** Features of the mortuary rack, such as the automatic trip handle for locking carriage and tray in place and the flared design for easy cleaning, are illustrated in the comprehensive folder.

For more details circle #525 on mailing card.

• The more than 125 products available from Nuclear-Chicago Corp., 229 W. Erie St., Chicago 10 are described in a new 76-page **General Catalog R.** Included is information on systems for use in biomedical research, clinical medicine and nuclear education.

For more details circle #526 on mailing card.

• **Wear-Ever Aluminum Alloy Clinical Utensils and Equipment,** including Wear-Ever Fresh-O-Matic for hot packs and compresses, are described and illustrated in a catalog recently released by Wear-Ever Aluminum, New Kensington, Pa.

For more details circle #527 on mailing card.

• Information on the construction, sizes, performance and other features of Kato AC generators is given in **Bulletin Form ACG958** recently released by Kato Engineering Co., Mankato, Minn.

For more details circle #528 on mailing card.

• The entire list of **Bobrick Soap Dispensers** is included in the new **General Catalog No. P-5806** released by Bobrick Dispensers, Inc., 1214 Nostrand Ave., Brooklyn 25, N.Y. Detailed specifications and data on more than 25 dispensers are included in the booklet which has a front-page index for convenient reference. In addition to the purchasing information given, the catalog includes the Bobrick "Service to Architects" and "Special Designer's Notes."

For more details circle #529 on mailing card.

• A catalog featuring **"Instrumentation for the Nuclear Sciences"** is now available from the Medical Division of Nuclear Measurements Corp., 2460 N. Arlington Ave., Indianapolis 18, Ind. Photographs, specifications, descriptive information and prices of the precision radiation detection and measuring instruments for medical use and clinical research are included in the catalog.

For more details circle #530 on mailing card.

• New steel architectural products added to the **Stran-Steel line** are presented in a 24-page catalog released by Stran-Steel Corp., Unit of National Steel Corp., Detroit 29, Mich. Complete technical information on the new items, as well as on the entire Stran-Steel line of joists, studs, channels, beams, C-sections, roof deck and curtain wall is contained in the catalog.

For more details circle #531 on mailing card.

Book Announcements

Burrows, Porter and Moulder, "Textbook of Microbiology," 17th ed., 954 pp., $14. Nixon and Cozens, "An Introduction to Physical Education," 5th ed., 287 pp., $4.25. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.**

For more details circle #532 on mailing card.

Suppliers' News

Physicians' Record Co., printers and publishers of medical record forms and professional texts, announces removal of its office and printing plant to a new building at **3000 S. Ridgeland Ave., Berwyn, Ill.,** as of May 1. The modern facilities provide the additional space required to meet the increasing demand for products and services.

Ritter Company, Inc., 404 West Ave., Rochester 3, N.Y., manufacturer of medical, hospital and dental equipment, announces the formation of a **Foreign Operations Division** under the direction of **Mr. Arsen L. Yakoubian.** The new division will coordinate the activities of Ritter foreign subsidiaries and handle export sales of the parent company.

Super Flaker SF-75WSF
Max. daily output 200 lbs. Occupies 5 sq. ft. floor space. Storage bin capacity approx. 100 lbs.

Super Flaker SF-1F
Max. daily output 350 lbs. Occupies 3 sq. ft. floor space.

Super Flaker SF-3WSF
Max. daily output 1050 lbs. Occupies 8 sq. ft. floor space. Storage bin capacity approx. 350 lbs.

Super Bin SB-750 with Scotsman Super Flaker.

The Royal Line of Ice Machines

Model SF-5E
Max. daily output up to 2000 lbs. Takes 5 sq. ft. floor space.

SCOTSMAN ICE MACHINES

World's Largest Line . . . World's Largest Seller

SUPER CUBER SC-500E
Ice Capacity—Up to 500 lbs. Storage Capacity — Stainless steel bin stores up to 400 lbs.

SUPER CUBER SC-100F
Ice Capacity—Up to 110 lbs. Storage Capacity — Stainless steel bin stores up to 75 lbs.

SUPER CUBER SC-200F
Ice Capacity—Up to 225 lbs. Storage Capacity — Stainless steel bin stores up to 150 lbs.

Combination Ice Machine and Drink Dispenser
Two models—DSI, up to 350 lbs. daily capacity—DS2, up to 550 lbs. daily.

PLUS DOZENS OF OTHER SCOTSMAN MODELS FOR EVERY ICE NEED!

SCOTSMAN
ICE MACHINES
More than 50 models of Super Flakers Super Cubers • Super Bins • Combination Ice Machines and Drink Dispensers

Make your own SCOTSMAN ice for as little as 8¢ per 100 lbs! Send for FREE 44-page booklet, "How To Use An Ice Machine."

NAME_____

ADDRESS_____

CITY_____ STATE_____

MAIL TO: **SCOTSMAN ICE MACHINES**
Queen Products Division, King-Seeley Corporation
95 Front St., Albert Lea, Minnesota
EXPORT OFFICE: 15 Williams St., New York, N. Y.

For additional information, use postcard facing Cover 3.

INDEX TO "WHAT'S NEW

Pages 207-234

Key

497 Surface Illuminators
Appleton Electric Co.

498 Sprayed Base Shapes
Natco Corp.

499 Astrilite
American Sterilizer Co.

500 Elastic Adhesive Tape
Johnson & Johnson

501 "Wax Stripper"
J. I. Holcomb Mfg. Co., Inc.

502 Repositioned Pump Filters
Gomco Surgical Mfg. Corp.

503 Caddy-Veyor and Nylon Belting
Caddy Corp. of America

504 Patient Prep-Card Series
Franklin C. Hollister Co.

505 Hygienered Blankets
Chatham Mfg. Co.

506 New V-Line Models
Victory Metal Mfg. Corp.

507 Four New Acoustical Materials
Armstrong Cork Co.

508 No. 978 Folding Chair
Durham Mfg. Corp.

509 Puregine Protective Rinse
Puretine Inc. Gallowhur Chemical Corp.

510 Linen Handling Cart
Ferno Mfg. Co.

511 Filter Grid Basket
Continental Coffee Co.

512 35-Gallon Refuse Container
Rubbermaid, Inc.

513 Ellit Ampule
Baltimore Biological Lab., Inc.

514 Folding Utility Truck
White Mop Wringer Co.

515 Garment Racks
Berroughs Mfg. Co.

516 Sterile Disposable Needle
Hypo Surgical Supply Corp.

517 Double Blood-Pack Unit
Fenwal Laboratories

518 Colorlith
Johns-Manville

519 Wood Grain Serving Trays
Cambro Mfg. Co.

520 Lead Plastic Apron
Picker X-Ray Corp.

521 BPL Surface Sterilant
Wilmot Castle Co.

Key

522 Napkin Dispensing Package
Kimberly-Clark Corp.

523 Tilt-Out Washer
Super Laundry Machinery Co.

524 Fire Retardant Paint
E. I. du Pont de Nemours & Co.

525 Iodet Gloss Sanitizer
The DuBois Co., Inc.

526 Rolls-Rack
Zola Banquetier Co.

527 Whirlwind Mowers
Toro Mfg. Corp.

528 Bulk Food Conveyors
The Colson Corp.

529 Two-Speed Floor Machines
General Floorcraft, Inc.

530 Model 1000 Enlarger-Printer
Charles Bruning Co., Inc.

531 AR-3 Liquid Oxygen Cylinder
Ohio Chemical

532 Portion-Pack Ketchup
H. J. Heinz Co.

533 Model 572 Food Cart
Kent, Cambro Works, Atlas Div.

534 Wash Room Cart
Forbes Brothers Co.

535 Micro-Chemistry Centrifuge
Clay-Adams, Inc.

536 11 Generating Plants
D. W. Onan & Sons, Inc.

537 Poker Chip Dish Dollies
Bucks County Enterprises, Inc.

538 Personal Page
Hauck Engineering Co.

539 Director "Auto-Stat"
American Photocopy Equipment Co.

540 Gyro-Magic Floor Machine
Advance Floor Machine Co.

541 Space-Maker Bedside Cabinet
Hospital Supply and Development Co.

542 Improved Anchor Hinge
McKinney Mfg. Co.

543 Cor-Tyzine and Neozo-Tyzine
Charles Pfizer & Co., Inc.

544 Deltaseval
Squibb

545 Stenisone
Organon, Inc.

546 Elmiron
The William S. Merrell Co.

547 Calginase and Combinase
Mead Johnson & Co.

Key

548 Dermil
Schering Corp.

549 "Ellison Balanced D
Ellison Bronze C

550 Porcelain Enamel C
The Erie Enamel

551 "New Way to Keep
Conkil Div.

552 Complete Catalog
Bloomfield Indus

553 "Your Next Paint Jo
The Tremco Mfg.

554 "Tornado Method of
Brewer Electric M

555 Surgical Catalog S-5
Randall Faichney

556 Washroom Cabinet C
Crown Zellerbach

557 "Intramuscular Iron
Lakeside Laborat

558 Permanent Drinking
Anchor Plastics

559 "Controlling Indoor
Johnson Service

560 "Processing of Nurs
Southern Cross

561 Bulletin No. 454
Herman H. Sticht

562 Catalog #50
Cardley & Hayes

563 "Radiation Monitorin
Eastman Kodak

564 "New Cost-Cutting
Campbell Soup

565 Folder B-540
Market Forge Co

566 General Catalog R
Bunker-Clancy

567 Clinical Utensils and
Wear-Ever Alum

568 Bulletin ACG858
Keto Engineering

569 General Catalog No.
Bobrick Dispenser

570 "Instrumentation for
Nuclear Measure

571 Complete Structural
Stran-Steel Corp.

572 Books
W. B. Saunders

USE THESE CARDS

(We pay the postage)

I am interested in the items circled—

437	438	439	440	441	442
443	444	445	446	447	448
449	450	451	452	453	454
455	456	457	458	459	460
461	462	463	464	465	466
467	468	469	470	471	472
473	474	475	476	477	478
479	480	481	482	483	484
485	486	487	488	489	490
491	492	493	494	495	496
497	498	499	500	501	502
503	504	505	506	507	508
509	510	511	512	513	514
515	516	517	518	519	520
521	522	523	524	525	526
527	528	529	530	531	532

533	534	535	536	537	538
539	540	541	542	543	544
545	546	547	548	549	550
551	552	553	554	555	556
557	558	559	560	561	562
563	564	565	566	567	568
569	570	571	572	573	574
575	576	577	578	579	580
581	582	583	584	585	586
587	588	589	590	591	592
593	594	595	596	597	598
599	600	601	602	603	604
605	606	607	608	609	610
611	612	613	614	615	616
617	618	619	620	621	622
623	624	625	626	627	628
629	630	631	632	633	634
635	636	637	638	639	640
641	642	643	644	645	646
647	648	649	650	651	652
653	654	655	656	657	658
659	660	661	662	663	664
665	666	667	668	669	670
671	672	673	674	675	676
677	678	679	680	681	682
683	684	685	686	687	688
689	690	691	692	693	694
695	696	697	698	699	700
701	702	703	704	705	

NAME

INSTITUTION

ADDRESS CITY ZONE

☐ Enter my one year subscription and bill me for $5, ☐

EW"

...orp.
...ced Doors"
...ase Co., Inc.
...nel Curtain Walls
...nameling Co.
...Keep Medical Records"
...log
...Industries
...int Job"
...Mfg. Co.
...od of Boiler Cleaning"
...tric Mfg. Co.
...og E-85
...chney Corp.
...inet Catalog
...erbach Corp.
... Iron Therapy"
...boratories, Inc.
...hing Tubes
...rics Co., Inc.
...door Weather"
...rvice Co.
... Nursing Bottles"
...ress Mfg. Corp.
...Bricht Co., Inc.
...Hayes
...nitoring"
...odak
...ting Recipes"
...Soup Co.
...ge Co.
...g R
...cago Corp.
...s and Equipment
...Aluminum, Inc.
...ering Co.
...g No. P-5000
...ponsors, Inc.
...n for Nuclear Sciences"
...easurements Corp.
...urcl Systems
...Corp.
...ders Co.

INDEX TO ADVERTISEMENTS ON FOLLOWING PAGE

TO REQUEST PRODUCT INFORMATION FOLD THIS FLAP OUT AND USE THESE CARDS

(We pay the postage)

The two cards below are detachable and are addressed to us. With this flap folded out you can turn through the magazine for the items on which you want further information.

When, in either an advertisement or "What's New", you locate the product, turn to the index to advertisements on the following page or to the index of "What's New" items (left) where you will find the key number for the item. Items advertised are listed alphabetically by manufacturer. "What's New" items are in Key Number order. Circle the corresponding key number on the card below for each item in which you are interested. The second card is for the use of someone else who may also want product data.

Detach and mail — no postage required.

May, 1959 (a)

541	542	543	544	545	546
555	556	557	558	559	560
569	570	571	572	573	574
583	584	585	586	587	588
597	598	599	600	601	602
611	612	613	614	615	616
625	626	627	628	629	630
639	640	641	642	643	644
653	654	655	656	657	658
667	668	669	670	671	672
681	682	683	684	685	686
695	696	697	698	699	700

I am interested in the items circled—

457	458	459	460	461	462
463	464	465	466	467	468
469	470	471	472	473	474
475	476	477	478	479	480
481	482	483	484	485	486
487	488	489	490	491	492
493	494	495	496	497	498
499	500	501	502	503	504
505	506	507	508	509	510
511	512	513	514	515	516
517	518	519	520	521	522
523	524	525	526	527	528
529	530	531	532		

May, 1959 (b)

533	534	535	536	537	538	539	540	541	542	543	544	545	546
547	548	549	550	551	552	553	554	555	556	557	558	559	560
561	562	563	564	565	566	567	568	569	570	571	572	573	574
575	576	577	578	579	580	581	582	583	584	585	586	587	588
589	590	591	592	593	594	595	596	597	598	599	600	601	602
603	604	605	606	607	608	609	610	611	612	613	614	615	616
617	618	619	620	621	622	623	624	625	626	627	628	629	630
631	632	633	634	635	636	637	638	639	640	641	642	643	644
645	646	647	648	649	650	651	652	653	654	655	656	657	658
659	660	661	662	663	664	665	666	667	668	669	670	671	672
673	674	675	676	677	678	679	680	681	682	683	684	685	686
687	688	689	690	691	692	693	694	695	696	697	698	699	700
701	702	703	704	705									

TITLE

ZONE STATE

, ☐ Foreign $7

NAME TITLE

INSTITUTION

ADDRESS CITY ZONE STATE

☐ Enter my one year subscription and bill me for $5, ☐ Foreign $7

INDEX TO ADV

FIRST CLASS
PERMIT NO. 137
CHICAGO, ILL.

BUSINESS REPLY MAIL
No Postage Stamp Necessary If Mailed in the United States

POSTAGE WILL BE PAID BY

THE MODERN HOSPITAL

919 NORTH MICHIGAN AVENUE

CHICAGO 11, ILLINOIS

BUSINES
No Postage Stamp Neces

POSTAG

THE

VERTISEMENTS

FIRST CLASS
PERMIT NO. 137
CHICAGO, ILL.

NESS REPLY MAIL
Necessary If Mailed in the United States

STAGE WILL BE PAID BY

THE MODERN HOSPITAL

919 NORTH MICHIGAN AVENUE

CHICAGO 11, ILLINOIS

(HPF) after company name indicates that further descriptive data are filed in catalog space in Hospital Purchasing File—36th Edition.

CONTROL YOUR FOOD COSTS...

ROUND CASSEROLE

SERVE UNIFORM PORTIONS *in*

HALL
Secret Process
FIREPROOF CHINA
AVAILABLE IN 26 BEAUTIFUL COLORS

Hall Casseroles make portion control automatic. The capacity of the dish guarantees a uniform serving to each guest . . . you can determine costs and set menu prices with accuracy. Recipes served in Hall China look and taste better . . . and can be sold at better prices. Write for Bulletin SM-1.

THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO
The World's Largest Manufacturer of Fireproof Cooking China

OVAL FISH CASSEROLE

OVAL CASSEROLE—HANDLED

NEW YORK CASSEROLE

INDIVIDUAL STEW POT—HANDLED

NEW Hospital Engineered

PRO-CAP

by SEAMLESS

Packs the Tack that Sticks Faster than Any Other Tape

UNMATCHED TACK—PRO-CAP's new mass offers up to 20% greater sticking power than the best previous performance by PRO-CAP or any other adhesive tape. PRO-CAP takes hold fast, won't curl or ridge, pulls clean and leaves no sticky residue. PRO-CAP now combines maximum tack and plasticity with the softest practical wind.

NO IRRITATION—Only PRO-CAP contains zinc caprylate and proprionate to inhibit staph, other germs and fungi.[1,2] PRO-CAP stays on the patient longer without causing itching or irritation . . . leaves no slimy film on the skin after removal. Hospital users report savings both on tape costs and nursing time.

NEW PACKAGE . . . NEW WIND—keep PRO-CAP factory fresh until used.

New wind permits economical last-inch use . . . doesn't drive mass into cloth with consequent gapping.

Available in white and flesh colors, regular and service weights and in Stay-Dry—all in standard cuts. Ask your hospital supply dealer to show you a roll today.

PRO-CAP is the registered trademark of the Seamless Rubber Company.

1. Humphries, R. E.: J. Invest. Dermat. **9**:219, (Nov.) 1947.
2. Peck, S. M., *et al.*: J. Invest. Dermat. **10**:367, (May) 1948.

HOSPITAL DIVISION

THE SEAMLESS RUBBER COMPANY

NEW HAVEN 3, CONN.